ERK'S COPY

TRANSCRIPT OF RECORD

Supreme Court of the United States

OCTOBER TERM, 1935.

No. 602

NEW YORK LIFE INSURANCE COMPANY,
PETITIONER,

vs.

DEMETRIOS P. VIGLAS

ON WRIT OF CERTIORARI TO THE UNITED STATES CIRCUIT COURT OF APPEALS FOR THE FIRST CIRCUIT

PETITION FOR CERTIORARI FILED NOVEMBER 23, 1935.

CERTIORARI GRANTED DECEMBER 23, 1935.

SUPREME COURT OF THE UNITED STATES

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JUDD & DETWEILLER (INC.), PRINTERS, WASHINGTON, D. C., JANUARY 10, 1936

—7296-C

[fol. 1] [Caption omitted]

IN UNITED STATES DISTRICT COURT, DISTRICT OF MASSACHUSETTS

No. 5790. Law Docket

DEMETRIOS P. VIGLAS, Plaintiff,

v.

NEW YORK LIFE INSURANCE COMPANY, Defendant

WRIT OF ATTACHMENT

[SEAL.]

MASSACHUSETTS DISTRICT, ss:

The President of the United States of America, to the Marshal of our District of Massachusetts, or his Deputy, Greeting:

We command you to attach the goods or estate of New York Life Insurance Company, a corporation duly organized and existing under the laws of the state of New York and having an usual place of business in Boston, in our District of Massachusetts, to the value of fifteen thousand dollars, and summon the said defendant, (if it may be found in your district), to appear before our Judge of our District Court, next to be holden at Boston, within and for our said District of Massachusetts, on the first Tuesday of Decem-
[fol. 2] ber, then and there, in our said court, to answer unto Demetrios P. Viglas, of Boston, Suffolk County, Massachusetts, in an action of contract.

To the damage of the said plaintiff (as he says) the sum of fifteen thousand dollars, which shall then and there be made to appear, with other due damages. And have you there this writ, with your doings therein.

Witness, the Honorable James A. Lowell, at Boston, the ninth day of November, in the year of our Lord one thousand nine hundred and thirty-three.

James S. Allen, Clerk, by Helen I. Tweedy, Deputy Clerk.

OFFICER'S RETURN ON WRIT

UNITED STATES OF AMERICA,
Massachusetts District, ss:

Boston, November 9, 1933.

Pursuant hereunto I have this day attached a chip as the property of the within-named New York Life Insurance Company, and thereafter on the same day I summoned the said defendant corporation to appear at court and answer as within directed by giving in hand to Merton L. Brown, Commissioner of Insurance for the Commonwealth of Massachusetts, at Boston, in said District, two copies of the within writ together with two original summons to this writ; also $2.00, his statutory fee.

William J. Keville, United States Marshal, by Jeremiah F. Sullivan, Deputy.

The writ in this cause is dated the ninth day of November, 1933, and was duly entered at the December Term of this court, A. D. 1933.

IN UNITED STATES DISTRICT COURT

DECLARATION—Filed December 5, 1933

[Memorandum.—Copy of declaration is here omitted, as a substituted declaration was subsequently filed by consent and will be found hereafter recorded. James S. Allen, Clerk.]

[fol. 3] IN UNITED STATES DISTRICT COURT

ANSWER—Filed December 15, 1933

The defendant in the above case denies each and every material allegation in the plaintiff's writ and declaration contained.

By its Attorney, F. H. Nash.

IN UNITED STATES DISTRICT COURT

MOTION FOR LEAVE TO AMEND WRIT—Filed by consent November 13, 1934; allowed November 16, 1934

Now comes the plaintiff and respectfully moves that he be permitted to amend his writ by changing the ad damnum thereof from $15,000 to $20,000.

By his Attorney, Harris J. Booras.

IN UNITED STATES DISTRICT COURT

PLAINTIFF'S SUBSTITUTE DECLARATION—Filed by consent November 13, 1934

Count 1. The plaintiff says that on or about the 7th day of February, 1927, he entered into a contract of insurance with the defendant, a copy of which policy of insurance is filed herewith and marked "Exhibit A." That, as appears by said contract, the plaintiff was to pay the defendant the sum of $76 annually as premium, in semi-annually payments of $38 each on the seventh days of February and August of each year, for a period of twenty years, or until death, or until the happening of total disability, as therein provided; that the face amount of said policy was $2,000; that under the terms of said contract the plaintiff was to pay premiums for twenty years, which premiums were to be waived by the company in accordance with certain provi- [fol. 4] sions in said contract; the policy was to be in full force and effect during the entire life of the plaintiff; that the plaintiff, at his election, after the policy was in effect for three years, could claim the cash surrender value of the policy as therein provided.

The plaintiff further says that on or about September 11, 1931, he became permanently and totally disabled within the terms and provisions of the contract; that in addition to his being totally and permanently disabled, as provided in the first clauses of the total and permanent disability section of said contract, the plaintiff says he lost the total and irrecoverable use of one hand and one foot; that because of said total and permanent disability, of which the plaintiff made due proof, the defendant commenced pay-

ing the plaintiff disability benefits on October 11, 1931, at the rate of $20 per month, in accordance with said contract, and continued paying said monthly benefits up to and including July 11, 1933, and gave the plaintiff statements waiving the payment of the premiums due on February 7, August 7, 1932, and February 7, 1933; that on or about September 1, 1933, the defendant refused to make the monthly payment due August 11, 1933, and refused to waive the semi-annual premium due August 7, 1933, asserting to the plaintiff as its ground for such refusal that, since it appeared to the defendant that for some time past the plaintiff had not been continuously totally disabled within the meaning of the disability benefit provision of the policy, the defendant would make no further monthly disability payments, and that the premiums due on and after August 7, 1933, would be payable in conformity with the terms of the contract.

Upon the expiration of the days of grace after August 7, 1933, for the payment of the semi-annual premium, the defendant, on or about September 19, 1933, declared the policy as lapsed upon its records, the premiums not having been waived by the defendant nor paid by the plaintiff. That thereupon, the plaintiff having been continuously, from September 11, 1931, totally and permanently disabled, and also being then totally and permanently disabled within the provisions of the contract, and that he having on his part complied with, was complying with and was ready and [fol. 5] willing to comply with in the future all the conditions, obligations and terms of said contract, which were by him to be observed, complied with, and performed, elected to treat said wrongful refusal of the defendant to perform its obligations under said contract as a repudiation and renunciation of the entire contract, which relieved the plaintiff from his obligations thereunder. The plaintiff further says that he is no longer an insurable risk and cannot procure another policy to take the place of the contract so repudiated by the defendant, and, further, that his total and permanent disability as defined within the provisions of the contract will continue for the rest of his life.

The plaintiff says that on or about the date of said wrongful breach, repudiation and renunciation of the contract by the defendant, the plaintiff had an expectancy of life, in accordance with the American Table of Mortality, of thirty-

six years. That said contract was executed on February 7, 1927, which is about six years prior to the date of the wrongful breach by the defendant; that on the forty-second anniversary of said policy said contract would have a cash surrender value of $1,408; that the plaintiff, because of the wrongful breach, termination, renunciation and repudiation of the said contract by the defendant, claims damages for the total breach thereof, and says that the defendant owes him for breach of the said life insurance contract the cash surrender value of this policy on its forty-second year the sum of $1,408.

Count. 2. The plaintiff says that on or about the seventh day of February, 1927, he entered into a contract of insurance with the defendant, a copy of which policy of insurance is filed herewith and marked "Exhibit A". That, as appears by said contract, the plaintiff was to pay the defendant the sum of $76 annually as premium, in semi-annual payments of $38 each on the seventh days of February and August of each year, for a period of twenty years, or until death, or until the happening of total disability, as therein provided; that the face amount of said policy was $2,000; that under the terms of said contract the plaintiff was to pay premiums for twenty years, which premiums were to be waived by the company in accordance with certain provisions in said contract; the policy was to be in full force and effect during the entire life of the plaintiff; that the [fol. 6] plaintiff, at his election, after the policy was in effect for three years, could claim the cash surrender value of the policy as therein provided.

The plaintiff further says that on or about September 11, 1931, he became permanently and totally disabled within the terms and provisions of the contract; that in addition to his being totally and permanently disabled, as provided in the first clauses of the total and permanent disability section of said contract, the plaintiff says he lost the total and irrecoverable use of one hand and one foot; that because of said total and permanent disability, of which the plaintiff made due proof, the defendant commenced paying the plaintiff disability benefits on October 11, 1931, at the rate of $20 per month, in accordance with said contract, and continued paying said monthly benefits up to and including July 11, 1933, and gave the plaintiff statements waiving the payment of

the premiums due on February 7, August 7, 1932, and February 7, 1933; that on or about September 1, 1933, the defendant refused to make the monthly payment due August 11, 1933, and refused to waive the semi-annual premium due August 7, 1933, asserting to the plaintiff as it ground for such refusal that since it appeared to the defendant that for some time past the plaintiff had not been continuously totally disabled within the meaning of the disability benefit provision of the policy, the defendant would make no further monthly disability payments, and that the premiums due on and after August 7, 1933, would be payable in conformity with the terms of the contract. Upon the expiration of the days of grace after August 7, 1933, for the payment of the semi-annual premium, the defendant, on or about September 19, 1933, declared the policy as lapsed upon its records, the premiums not having been waived by the defendant nor paid by the plaintiff. That thereupon, the plaintiff having been continuously, from September 11, 1931, totally and permanently disabled, and also being then totally and permanently disabled within the provisions of the contract, and that he having on his part complied with, was complying with and was ready and willing to comply with in the future, all the conditions, obligations and terms of said contract, which were by him to be observed, complied with and performed, elected to treat said wrongful refusal of the defendant to perform its obligations under said [fol. 7] contract as a repudiation and renunciation of the entire contract, which relieved the plaintiff from his obligations thereunder. The plaintiff further says that he is no longer an insurable risk and cannot procure another policy to take the place of the contract so repudiated by the defendant, and, further, that his total and permanent disability as defined within the provisions of the contract will continue for the rest of his life.

That on or about the date of said wrongful breach of the contract by the defendant, the plaintiff had an expectancy of life, in accordance with the American Table of Mortality, of thirty-six years, and that as of said date of the defendant's breach the defendant owed to the plaintiff the sum of $15,900 damages for breach of the total and permanent disability provisions, in accordance with the following schedule:

Item 1. 39 months disability from July 11, 1933, at $20 per month	$780.00
Item 2. For the next 60 consecutive months after the first period, at $30 per month	1,800.00
Item 3. 333 months of disability next after the previous periods, at $40 per month	13,320.00
	$15,900.00

By his Attorney, Harris J. Booras.

EXHIBIT A

[Memorandum.—By consent of parties insurance policy, marked Exhibit "A," and referred to in the foregoing plaintiff's substitute declaration, is not here printed, but is to be transmitted with the record on appeal. James S. Allen, Clerk.]

IN UNITED STATES DISTRICT COURT

DEMURRER.—Filed November 14, 1934

The defendant demurs to each count of the plaintiff's declaration and for cause of demurrer shows:

[fol. 8] The facts alleged do not support the plaintiff's conclusion that upon the defendant's assertion that, the plaintiff being no longer totally and permanently disabled within the terms of the policy, it would not continue to make the monthly payments and waive the semi-annual premiums, thereupon the plaintiff acquired a right to recover from the defendant forthwith the aggregate of all benefits which would be payable to him if he should live out a normal expectancy under the Mortality Table while continuously totally disabled.

The facts alleged show a right in the plaintiff only to sue for monthly instalments claimed to be already due and for premiums which he claims ought to have been waived, prior to the date of the writ, and a right in equity if seasonably exercised to restrain the defendant from declaring the policy lapsed for non-payment of premiums.

Wherefore the declaration sets forth a cause of action only for payments under the contract between the date as of which the defendant ceased to continue monthly payments and waiver of premiums, namely, July 11, 1933, and the date of the writ, namely, November 9, 1933, as follows: The payments of $20 each claimed by the plaintiff to be due on August 11, September 11 and October 11, 1933, and waiver of the semi-annual premium of $38 due August 7, 1933, a total of $98, which is a sum beneath the jurisdiction of this court.

By its Attorney, F. H. Nash.

Certificate

I, Frederick H. Nash, attorney for the defendant in the above-entitled case, certify that the foregoing demurrer is filed in good faith and is based upon substantial grounds and is not intended merely for delay.

Frederick H. Nash.

Recital as to Order Sustaining Demurrer

On the nineteenth day of November, 1934, said cause is set down for hearing on demurrer, the Honorable Hugh D. McLellan, District Judge, sitting, and after due consideration thereon had, to wit, November 22, 1934, a memorandum of the court is announced, sustaining demurrer.

[fol. 9] On the twenty-eighth day of November, A. D. 1934, the following Motion for Entry of Judgment is filed and assented to:

In United States District Court

Motion for Entry of Judgment—Filed November 28, 1934

Whereas the defendant's demurrer to the plaintiff's declaration in the above-entitled action was sustained on November 22, 1934, by order of Judge McLellan,

The defendant now moves that judgment for the defendant be entered forthwith.

By its Attorney, F. H. Nash.

IN UNITED STATES DISTRICT COURT

JUDGMENT

On the said twenty-eighth day of November, the foregoing motion for entry of judgment is allowed by the court.

Thereupon, to wit, November 28, 1934, it is considered by the court, the Honorable Hugh D. McLellan, District Judge, sitting, that the said Demetrios P. Viglas, plaintiff, take nothing by his said writ, and that the said New York Life Insurance Company, defendant, recover of the said plaintiff its costs of suit taxed at —.

IN UNITED STATES DISTRICT COURT

MEMORANDUM ON DEMURRER—November 22, 1934

The parties are agreed that it is desirable to have the question as to the validity of the declaration solved before they embark upon a trial which they say will be somewhat long and will involve considerable expense for expert testimony.

The demurrer, which attacks both counts of the declaration in the particulars specifically pointed out (Massachusetts General Laws, Chapter 231, Section 18, Clause 4) was argued at length. While there is authority in support of the declaration (see the majority opinion in Federal Life Insurance Company v. Rascoe, 12 Fed. (2d) 693, and Equitable Life Assurance Society v. Pool, 71 S. W. (2d) 455 [Arkansas]); there is also authority in support of the demurrer (See Kimel et al. v. Missouri State Life Insurance Company, 71 Fed. (2d) 921; Parks v. Maryland Casualty Company, 59 Fed. (2d) 736; LaVecchia v. Connecticut Mutual Life Insurance Company, 1 Fed. Supp. 588; Kith- [fol. 10] cart v. Metropolitan Life Insurance Company, 1 Fed. Supp. 719; Wyll v. Pacific Mutual Life Insurance Company, 3 Fed. Supp. 483; and Judge Denison's dissenting opinion in Federal Life Insurance Company v. Rascoe, surpa. See also Judge West's statement to the jury [as yet unpublished] of his reasons for ordering a verdict for the defendant in McLaughlin v. New York Life Insurance Company, in which he distinguishes that case from the Rascoe

case). Aetna Life Insurance Company v. Geher, 50 Fed. (2d) 657, and Pierce v. Tennessee Coal, Iron and Railroad Company, 173 U. S. 1, cited at the argument, are not at all controlling, so far as the question herein involved is concerned. Considering the nature of the contract, the alleged breach thereof by the defendant is not of such a character as to warrant recovery now of the present value of payments to be made in the future. This conclusion does not rest upon the cases decided in jurisdictions like Massachusetts, where recovery based upon anticipatory breaches is not favored. It seems to me that by the weight of authority this case goes beyond the limits of the rule which prevails in jurisdictions where the doctrine of anticipatory breach is accepted.

The demurrer is sustained.

Hugh D. McLellan, District Judge.

Recital as to Order Allowing Appeal

From the foregoing judgment, a petition for appeal to the United States Circuit Court of Appeals for the First Circuit was filed by the plaintiff on the seventeenth day of December, 1934, and allowed by the court on the eighteenth day of said December, bond on appeal having been waived.

In United States District Court

Assignment of Errors—Filed December 17, 1934

Now comes the plaintiff in this action, in connection with his petition for allowance of appeal, and makes the following assignment of errors which he avers occurred by the order of the District Court in said cause, and the rendition of judgment against the plaintiff appearing upon the record herein:

[fols. 11 & 12] 1. The court erred in sustaining the demurrer to the plaintiff's substitute declaration.

By his Attorney Harris J. Booras.

Recital as to Citation

A citation on appeal was issued on December 18, 1934, being made returnable in the United States Circuit Court of Appeals on January 17, 1935.

Clerk's certificate to foregoing transcript omitted in printing.

[Memorandum. An order of enlargement of time for docketing case to, and including February 16, 1935, is here omitted. A. I. Charron, Clerk.]

[fol. 13] IN UNITED STATES CIRCUIT COURT OF APPEALS FOR THE FIRST CIRCUIT, OCTOBER TERM, 1934

No. 3012

DEMETRIOS P. VIGLAS, Plaintiff, Appellant,

v.

NEW YORK LIFE INSURANCE COMPANY, Defendant, Appellee

Appeal from the District Court of the United States for the District of Massachusetts

Before Bingham, Wilson and Morton, JJ.

OPINION OF THE COURT—Filed July 13, 1935

MORTON, J.:

This is an appeal from a judgment for the defendant which was entered after a demurrer to the plaintiff's declaration had been sustained by the District Judge. The question presented is whether the plaintiff's declaration in its final form stated a cause of action within the jurisdiction of the Federal Court. There was the necessary diversity of citizenship.

In Count I of the declaration the plaintiff claimed $1408, as the cash surrender value of the policy in question at a future date. This amount is less than the jurisdictional requirement. The parties correctly assumed that there is no jurisdiction in the Federal Court unless Count II stated a good cause of action. This count is as follows:

"The plaintiff says that on or about the seventh day of February, 1927, he entered into a contract of insurance with the defendant, a copy of which policy of insurance is filed

herewith and marked 'Exhibit A'. That, as appears by said [fol. 14] contract, the plaintiff was to pay the defendant the sum of $76 annually as premium, in semi-annual payments of $38 each on the seventh days of February and August of each year, for a period of twenty years, or until death, or until the happening of total disability, as therein provided; that the face amount of said policy was $2,000; that under the terms of said contract the plaintiff was to pay premiums for twenty years, which premiums were to be waived by the company in accordance with certain provisions in said contract; the policy was to be in full force and effect during the entire life of the plantiff; that the plaintiff, at his election, after the policy was in effect for three years, could claim the cash surrender value of the policy as therein provided.

"The plaintiff further says that on or about September 11, 1931, he became permanently and totally disabled within the terms and provisions of the contract; that in addition to his being totally and permanently disabled, as provided in the first clauses of the total and permanent disability section of said contract, the plaintiff says he lost the total and irrecoverable use of one hand and one foot; that because of said total and permanent disability, of which the plaintiff made due proof, the defendant commenced paying the plaintiff disability benefits on October 11, 1931, at the rate of $20 per month, in accordance with said contract, and continued paying said monthly benefits up to and including July 11, 1933, and gave the plaintiff statements waiving the payment of the premiums due on February 7, August 7, 1932, and February 7, 1933; that on or about September 1, 1933, the defendant refused to make the monthly payment due August 11, 1933, and refused to waive the semi-annual premium due August 7, 1933, asserting to the plaintiff as its ground for such refusal that since it appeared to the defendant that for some time past the plaintiff had not been continuously totally disabled within the meaning of the disability benefit provision of the policy, the defendant would make no further monthly disability payments, and that the premiums due on and after August 7, 1933, would be payable in conformity with the terms of the contract. Upon the expiration of the days of grace after August 7, 1933, for the payment of the semi-annual pre-

mium, the defendant, on or about September 19, 1933, declared the policy as lapsed upon its records, the premiums not having been waived by the defendant nor paid by the plaintiff. That thereupon, the plaintiff having been con-
[fol. 15] tinuously, from September 11, 1931, totally and permanently disabled, and also being then totally and permanently disabled within the provisions of the contract, and that he having on his part complied with, was complying with and was ready and willing to comply with in the future, all the conditions, obligations and terms of said contract, which were by him to be observed, complied with and performed, elected to treat said wrongful refusal of the defendant to perform its obligations under said contract as a repudiation and renunciation of the entire contract, which relieved the plaintiff from his obligations thereunder. The plaintiff further says that he is no longer an insurable risk and cannot procure another policy to take the place of the contract so repudiated by the defendant, and, further, that his total and permanent disability as defined within the provisions of the contract will continue for the rest of his life.

"That on or about the date of said wrongful breach of the contract by the defendant the plaintiff had an expectancy of life, in accordance with the American Table of Mortality, of thirty-six years, and that as of said date of the defendant's breach the defendant owed to the plaintiff the sum of $15,900 damages for breach of the total and permanent disability provisions, in accordance with the following schedule:

Item 1. 39 months disability from July 11, 1933, at $20 per month	$780.00
Item 2. For the next 60 consecutive months after the first period, at $30 per month	$1,800.00
Item. 3. 333 months of disability next after the previous periods, at $40 per month	13,300.00
	$15,900.00"

The defendant's demurrer is as follows:

"The facts alleged do not support the plaintiff's conclusion that upon the defendant's assertion that, the plaintiff being no longer totally and permanently disabled within the

terms of the policy, it would not continue to make the monthly payments and waive the semi-annual premiums, thereupon the plaintiff acquired a right to recover from the defendant forthwith the aggregate of all benefits which would be payable to him if he should live out a normal expectancy under the Mortality Table while continuously totally disabled.

"The facts alleged show a right in the plaintiff only to sue for monthly instalments claimed to be already due and [fol. 16] for premiums which he claims ought to have been waived, prior to the date of the writ, and a right in equity if seasonably exercised to restrain the defendant from declaring the policy lapsed for non-payment of premiums.

"Wherefore the declaration sets forth a cause of action only for payments under the contract between the date as of which the defendant ceased to continue monthly payments and waiver of premiums, namely, July 11, 1933, and the date of the writ, namely, November 9, 1933, as follows: The payments of $20 each claimed by the plaintiff to be due on August 11, September 11 and October 11, 1933, and waiver of the semi-annual premium of $38 due August 7, 1933, a total of $98, which is a sum beneath the jurisdiction of this court."

The law on this subject has recently been stated in Mobley v. New York Life Insurance Co., U. S. Supreme Court, 27 May 1935. "Mere refusal, upon mistake or misunderstanding as to matters of fact or upon an erroneous construction of the disability clause, to pay a monthly benefit when due is sufficient to constitute a breach of that provision, but it does not amount to a renunciation or repudiation of the policy." Butler, J. See to Daley v. People's Bldg., etc., Assoc., 178 Mass. 13, 18 and Indiana Life Endowment Co. v. Reed, 103 N. E. 77. On the other hand "Repudiation by one party, to be sufficient in any case to entitle the other to treat the contract as absolutely and finally broken and to recover damages as upon total breach, must at least amount to an unqualified refusal or declaration of inability, substantially to perform according to the terms of his obligation." Butler, J. Citing authorities. See too Pierce v. Tenn. Coal, Iron, etc., Co., 173 U. S. 1; Lovell v. St. Louis Mutual Ins. Co., 111 U. S. 264; Parker v. Russell, 133 Mass. 74.

As we construe the declaration it alleges a complete and unqualified denial by the defendant of all liability on the policy. It states that the defendant not only refused to pay benefits due but wrongfully lapsed the policy for non-payment of premiums. An unconditional lapsing of the policy was a complete termination of it and a denial by the defendant of any further liability on it. There is no allegation [fol. 17] that the defendant recognizes any further rights of the plaintiff in the policy, or any further liability upon it. The facts alleged are essentially different from those in the Mobley case where it was held that the evidence did not show repudiation of the policy or a complete denial of liability on it by the company. On the allegations of the declaration we are of opinion that the plaintiff was entitled to maintain the action and, if the lapsing was found to be a complete and unqualified denial by the defendant of any further liability on the policy and was unjustified that the plaintiff would be entitled to recover damages equivalent to the value to him of the contract which was broken. See Day v. Conn. General Life Ins. Co., 45 Conn. 480; Merrick v. Northwestern Nat. Life Ins. Co., 102 N. W. 593; Indiana Life Endowment Co. v. Reed, 103 N. E. 77; and O'Neill v. Sup. Council, 57 Atl. 463. (Pitney, J.) in all of which it was said that on unjustified repudiation of a policy of insurance by the defendant company, the plaintiff might recover the value of the policy at the time when it was declared forfeited.

The doctrine of anticipatory breach which was discussed in argument has no application to the facts stated in the declaration. That doctrine, strictly stated, applies to situations in which the parties have made a bi-lateral executory contract looking to performance by each in the future and before the time for performance arrived one party notified the other that he will not go on. Roehm v. Horst, 178 U. S. 1 holds that an action against the repudiating party lies immediately, before time for his performance has arrived; and Daniels v. Newton, 114 Mass. 530, holds the contrary. Here the time for performance by the defendant had arrived and there was both a present breach and a complete repudiation of the entire contract. In Pierce v. Tenn, supra, repudiation by the defendant of an agreement by it to pay the plaintiff, who had been injured, stated monthly payments as long as his disability should continue, coupled

with non-payment of sums due, was held to warrant the [fol. 18] assessment of damages equivalent to the value to the plaintiff of the broken contract. In Lovell v. St. Louis Mutual Ins. Co., 111 U. S. 204, where the defendant company went out of business and transferred its assets to a new company, it was held that "the complainant had a right to consider it (the policy) as determined by the act of the company and to demand what was fully due him in the exigency. Of this we think there can be no doubt." Bradley, J., page 274. Here the company's act in lapsing the policy was, on the allegations, a determination of it by the company. In Parker v. Russell, 133 Mass. 74, failure by the defendant to make any payments for about two years on a contract to support the plaintiff during the latter's life was held to warrant a finding that the entire contract was broken and an assessment of damages equivalent to the value of the contract to the plaintiff.

The principle of those decisions applies to the present case. We perceive no sufficient reason why life insurance contracts should stand on any different or exceptional footing. For obvious reasons the continuance of a recognized contractual obligation by the company may be of importance to the insured (Roehm v. Horst, supra), especially where as in this case the obligation is for the regular payment of stipulated sums. If as is here alleged the insured has become uninsurable, the wrongful repudiation of the policy by the insurance company may be a matter of the utmost gravity. The proposition that, if a contract, made upon an executed consideration to pay an annuity, is broken by the refusal to pay the installments due and is completely repudiated by the promisor, the person entitled to the annuity has no redress except to bring actions for the installments as they become due, does not commend itself to us although several cases cited in Mobley v. N. Y. Ins. Co., 74 Fed. (2d) 588 (C. C. A. 5), have so held. With respect to War Risk insurance cases, also referred to in the Mobley opinion, in those that have come under our notice the issue has generally been whether the insured brought himself [fol. 19] within the terms of the policy. In few if any cases did the government repudiate or disavow the contract.

The fact that the plaintiff's right to receive further payments rested on certain conditions to be performed by him does not bar the recovery of damages. They are allowed in

many cases of that character. (173 U. S. 14 to 16.) Nor does the fact that the defendant's obligation was only to pay money prevent the assessment of damages for the entire value of the contract including future payments,—as the cases above referred to illustrate. Commercial paper stands on a special footing as was said in Roehm v. Horst, 178 U. S. 1 at 17.

The declaration asserts a claim based on the plaintiff's expectation of life according to the standard mortality tables. If such tables are admissible when the life in question is that of a person totally disabled and uninsurable,—which is a question to be decided in the first instance by the trial judge and on which we express no opinion,—plainly they are only evidence to be considered in connection with all the other evidence in estimating the value to the plaintiff of the contract which was broken.

The judgment of the District Court is reversed and the case is remanded to that court for further proceedings not inconsistent with this opinion; the appellant recovers costs of appeal.

[fol. 20] RECITAL AS TO HEARING

On April 11 and 12, 1935, this cause came on to be heard, and was fully heard by the court, Honorable George H. Bingham, Honorable Scott Wilson and Honorable James M. Morton, Jr., Circuit Judges, sitting.

IN UNITED STATES CIRCUIT COURT OF APPEALS

JUDGMENT—July 13, 1935

This cause came on to be heard April 11 and 12, 1935, upon the transcript of record of the District Court of the United States for the District of Massachusetts, and was argued by counsel.

Upon consideration whereof, It is now, to wit, July 13, 1935, here ordered, adjudged and decreed as follows: The judgment of the District Court is reversed and the case is remanded to that court for further proceedings not incon-

sistent with the opinion passed down this day; the appellant recovers costs of appeal.

By the Court.

Arthur I. Charron, Clerk.

RECITAL AS TO ORDER DENYING REHEARING

Thereafter, to wit, on August 6, 1935, a petition for rehearing was filed by appellee, which was denied by order of court on October 9, 1935.

RECITAL AS TO ORDER STAYING MANDATE

Thereafter, to wit, on October 10, 1935, mandate was stayed until further order of court.

Exhibit "A"

NEW YORK LIFE
INSURANCE COMPANY
A MUTUAL COMPANY

AGREES TO PAY

to PANAGIOTIS AND KYRIANCOULA VIGLAS, PARENTS OF THE INSURED, SHARE AND SHARE ALIKE *** Beneficiary
(with right on the part of the Insured to change the Beneficiary in the manner provided herein)

*** TWO THOUSAND *** Dollars
(THE FACE OF THIS POLICY)

upon receipt of due proof of the death of

*** DEMETRIOS P. VIGLAS *** the Insured,

or *** FOUR THOUSAND *** Dollars
(DOUBLE THE FACE OF THIS POLICY)

if such death resulted from accident as defined under "Double Indemnity" on the second page hereof and subject to the provisions therein set forth.

Either such sum will be increased by any outstanding dividend additions and dividend deposits as provided herein.

And upon receipt of due proof that the Insured is totally and presumably permanently disabled before age 60, as defined under "Total and Permanent Disability" on the second page hereof,

THE COMPANY AGREES TO PAY TO THE INSURED A MONTHLY INCOME

of * TWENTY *** Dollars, increasing after five and ten years of continuous disability, and to waive payment of premiums, as provided therein.**

This contract is made in consideration of the payment in advance of the sum of $ 38.00, the receipt of which is hereby acknowledged, constituting the first premium and maintaining this Policy for the period terminating on the SEVENTH day of AUGUST Nineteen Hundred and TWENTY-SEVEN, and of a like sum on said date and every SIX calendar months thereafter during the life of the Insured until premiums for TWENTY full years in all shall have been paid from the date on which this Policy takes effect.

The premium paying period may be shortened by application of dividend additions and dividend deposits as provided herein.

This Policy takes effect as of the SEVENTH day of FEBRUARY Nineteen Hundred and TWENTY-SEVEN, which day is the anniversary of the Policy.

THE BENEFITS AND PROVISIONS printed or written by the Company on the following pages are a part of this contract as fully as if they were recited at length over the signatures hereto affixed.

In Witness Whereof the NEW YORK LIFE INSURANCE COMPANY has caused this contract to be signed this SEVENTH day of FEBRUARY Nineteen Hundred and TWENTY-SEVEN

Edward B. Johnson
Secretary

Darwin P. Kingsley
President

925-62
L. P. L.
I. D.-D. I.

Registrar

Age 23 Insurance Payable at Death. Premiums Payable for 20 years unless Dividends Applied to Shorten Premium-Paying Period. Disability Benefits providing for Increasing Monthly Income. Double Indemnity for Fatal Accident. Annual Participation in Surplus.

Examined WD LE

21-22

DOUBLE INDEMNITY

The Double Indemnity provided on the first page hereof shall be payable upon receipt of due proof that the death of the Insured resulted directly and independently of all other causes from bodily injury effected solely through external, violent and accidental means and occurred within ninety days after such injury.

Double Indemnity shall not be payable if the Insured's death resulted from self-destruction, whether sane or insane; from the taking of poison or inhaling of gas, whether voluntary or otherwise; from committing an assault or felony; from war or any act incident thereto; from engaging in riot or insurrection; from participation as a passenger or otherwise in aviation or aeronautics; or, directly or indirectly, from infirmity of mind or body, from illness or disease, or from any bacterial infection other than bacterial infection occurring in consequence of accidental and external bodily injury. The Company shall have the right and opportunity to examine the body, and to make an autopsy unless prohibited by law.

Double Indemnity shall not apply to the Temporary Insurance or to the Paid-up Insurance provided herein under "Surrender Values", or to any Dividend Additions provided under "Participation in Surplus — Dividends".

The total premium stated on the first page hereof includes a SEMI annual premium of $ 1.64 for the Double Indemnity Benefit.

TOTAL AND PERMANENT DISABILITY

Disability shall be considered total whenever the Insured is so disabled by bodily injury or disease that he is wholly prevented from performing any work, from following any occupation, or from engaging in any business for remuneration or profit, provided such disability occurred after the insurance under this policy took effect and before the anniversary of the policy on which the Insured's age at nearest birthday is sixty.

Upon receipt at the Company's Home Office, before default in payment of premium, of due proof that the Insured is totally disabled as above defined, and will be continuously so totally disabled for life, or if the proof submitted is not conclusive as to the permanency of such disability, but establishes that the Insured is, and for a period of not less than three consecutive months immediately preceding receipt of proof has been, totally disabled as above defined, the following benefits will be granted:

(*a*) **Waiver of Premium.**—The Company will waive the payment of any premium falling due during the period of continuous total disability, the premium waived to be the annual, semi-annual or quarterly premium according to the mode of payment in effect when disability occurred.

(*b*) **Increasing Income Payments.**—The Company will pay to the Insured the monthly income stated on the first page hereof ($10 per $1,000 of the face of this policy) for each completed month from the commencement of and during the period of continuous total disability. The amount of the monthly income shall increase after sixty consecutive monthly payments have been made to one and one-half times such amount, and after sixty further consecutive monthly payments have been made to twice such amount. If disability results from insanity, payment will be made to the beneficiary in lieu of the Insured.

In event of default in payment of premium after the Insured has become totally disabled as above defined, the policy will be restored and the benefits shall be the same as if said default had not occurred, provided due proof that the Insured is and has been continuously from date of default so totally disabled and that such disability will continue for life or has continued for a period of not less than three consecutive months, is received by the Company not later than six months after said default.

The total and irrecoverable loss of the sight of both eyes or of the use of both hands or of both feet or of one hand and one foot shall constitute total disability for life.

Before making any income payment or waiving any premium, the Company may demand due proof of the continuance of total disability, but such proof will not be required oftener than once a year after such disability has continued for two full years. Upon failure to furnish such proof, or if the Insured performs any work, or follows any occupation, or engages in any business for remuneration or profit, no further income payments shall be made nor premiums waived. If the Insured shall furnish due proof that he has again become totally and presumably permanently disabled, as herein defined, the Disability Benefits herein provided shall be the same in amount as if no prior disability had existed.

The sum payable in any settlement of the policy shall not be reduced by income payments made nor by premiums waived under the above provisions. Dividends, loan and surrender values shall be the same as if the waived premiums had been duly paid. Any disability benefit due but unpaid at the time of the Insured's death shall be payable to the person entitled to the proceeds of the policy.

Disability Benefits shall not apply if the disability of the Insured shall result from self-inflicted injury or from military or naval service in time of war, or from engaging as a passenger or otherwise in aviation or aeronautics; nor shall these benefits apply to the Temporary Insurance or to the Paid-up Insurance provided herein under "Surrender Values", or to any Dividend Additions provided under "Participation in Surplus—Dividends".

The total premium stated on the first page hereof includes a SEMI annual premium of $ 4.32 for Disability Benefits.

Any premium due on or after the anniversary of the policy on which the age of the Insured at nearest birthday is sixty, will be reduced by the amount of premium charged for Disability Benefits. Upon written request signed by the Insured and upon return of this policy for proper indorsement, the Company will terminate this provision and thereafter the premium shall be reduced by the amount charged for Disability Benefits.

23-24

PARTICIPATION IN SURPLUS—DIVIDENDS

The proportion of divisible surplus accruing upon this Policy shall be ascertained annually. Beginning at the end of the second insurance year, and on each anniversary thereafter, such surplus as shall have been apportioned by the Company to this Policy shall at the option of the Insured be either

(*a*) Paid in cash; or

(*b*) Applied toward payment of premiums; or

(*c*) Applied to purchase a participating paid-up addition to the sum insured (herein referred to as Dividend Additions); or

(*d*) Left to accumulate at such rate of interest as the Company may declare on funds so held, but at a rate never less than three per cent compounded and credited annually. Such accumulated dividends (herein referred to as Dividend Deposits) may be withdrawn in cash by the Insured on any anniversary of the Policy or shall be payable at the maturity of the Policy to the person entitled to its proceeds.

If no option is selected, the dividend will be applied to the purchase of a dividend addition to the sum insured. The Insured may surrender any dividend addition for cash at any time not later than three months after any default in the payment of premium, and the cash value thereof shall never be less than the original cash dividend.

DIVIDENDS MAY BE APPLIED TO DECREASE NUMBER OF PREMIUM PAYMENTS OR MATURE POLICY AS AN ENDOWMENT

Whenever the cash value of the Policy including the cash value of any dividend additions and dividend deposits shall equal the net single premium at the attained age of the Insured for a fully paid participating Policy of the same kind and amount as this Policy, calculated on the same basis as the premium on this Policy, the Company, upon the written request of the Insured, will indorse this Policy as fully paid, whereupon the payment of premium will be discontinued; or, whenever said cash value shall equal the face amount of this Policy, the Company, upon due surrender of the Policy, will pay the face amount of the Policy in cash, less any indebtedness to the Company.

MISCELLANEOUS BENEFITS

Assignment.—Any assignment of this Policy must be made in duplicate and one copy filed with the Company at its Home Office. The Company assumes no responsibility for the validity of any assignment.

Change of Beneficiary.—The Insured may from time to time change the beneficiary, unless otherwise provided by indorsement on this Policy or unless there be an existing assignment of this Policy. Every change of beneficiary must be made by written notice to the Company at its Home Office accompanied by the Policy for indorsement of the change thereon by the Company, and unless so indorsed the change shall not take effect. After such indorsement the change will relate back to and take effect as of the date the Insured signed said written notice of change whether the Insured be living at the time of such indorsement or not, but without prejudice to the Company on account of any payment made by it before receipt of such written notice at its Home Office. In the event of the death of any beneficiary before the Insured the interest of such beneficiary shall vest in the Insured, unless otherwise provided herein.

Grace.—If any premium is not paid on or before the day it falls due the policy-holder is in default; but a grace of one month (not less than thirty days) will be allowed for the payment of every premium after the first, during which time the insurance continues in force. If death occurs within the period of grace the overdue premium will be deducted from the amount payable hereunder.

Interest Allowed at Settlement of Death Claims.—Interest will be allowed on the proceeds of the Policy payable as a death claim from date of receipt of due proof of death at any office of the Company until the date settlement is made at the Home Office. Interest shall be at the rate declared by the Company on such funds, but at a rate not less than three per cent per annum.

Reinstatement.—This Policy may be reinstated at any time within five years after any default, upon written application by the Insured and presentation at the Home Office of evidence of insurability satisfactory to the Company and upon payment of overdue premiums with five per cent interest thereon from their due date. Any indebtedness to the Company at date of default must be paid or reinstated with interest thereon in accordance with the loan provisions of the Policy.

Privilege of Change to Other Plans of Insurance.—At any time before default in payment of premium, provided the Insured is then less than 55 years of age and has not become disabled under the disability provisions hereof, the Insured may, without medical re-examination, exchange this Policy for a Policy upon any plan of insurance having a higher rate of premium issued by the Company at the time this Policy takes effect for the same amount as this Policy and containing the same Disability and Double Indemnity Benefits. Such exchange shall be effective upon surrender of this Policy and the payment of the difference in premiums with compound interest at the rate of six per cent per annum from the due date of each premium to the date of exchange; allowance will be made for any larger cash dividends on the new plan. The new Policy will take effect as of the date of this Policy and the premium will be at the rate which would have been charged if the Policy had been originally issued on the new plan.

Residence, Travel and Occupation.—This Policy is free of conditions as to residence, travel, occupation, and military or naval service, except as provided herein under Disability and Double Indemnity Benefits.

Rights of Insured.—The Insured, during his lifetime, and without the consent of the beneficiary, may receive every benefit, exercise every right and enjoy every privilege conferred upon the Insured by this Policy, unless otherwise provided by indorsement hereon.

25-26

OPTIONAL METHODS OF SETTLEMENT

The Insured, or in case the Insured shall not have done so, the beneficiary after the Insured's death, may, by written notice to the Company at its Home Office, make the proceeds of this Policy, in whole or in part, payable under one of the following options. Any such election or any change in election shall not take effect until indorsed on the Policy by the Company at its Home Office. The optional methods of settlement are available whether such proceeds are payable as a death claim or on maturity as an Endowment, or upon surrender of the Policy for its cash value, provided the instalment or interest payment to any payee is not less than $10.

Option 1.—The proceeds in whole or in part may be left with the Company subject to withdrawal at any time on demand in sums of not less than one hundred dollars. The Company will credit interest annually on the proceeds so left with it at such rate as it may each year declare on such funds, and guarantees that the rate shall be not less than three per cent.

Option 2.—The proceeds in whole or in part may be made payable in equal annual, semi-annual, quarterly or monthly instalments for a fixed period as may be agreed upon, in accordance with the following table.

Option 3.—The proceeds in whole or in part may be made payable in equal annual, semi-annual, quarterly or monthly instalments for a fixed period of five, ten or twenty years, as may be agreed upon, and for the remaining lifetime of the payee, in accordance with the following table.

Option 4.—The proceeds in whole or in part may be left with the Company at interest until the death of the payee. The Company will pay interest thereon annually, semi-annually, quarterly or monthly, as may be agreed upon, at such rate as the Company may declare each year on such funds, and guarantees that the interest per one thousand dollars of the proceeds shall be not less than $30 when paid annually, $14.89 when paid semi-annually, $7.42 when paid quarterly, or $2.47 when paid monthly.

Option 5.—The proceeds in whole or in part may be left with the Company at interest and paid in equal annual, semi-annual, quarterly or monthly instalments of such amount as may be agreed upon until the entire proceeds left with the Company, including interest thereon as provided in Option 1, have been paid, provided that the fixed amount payable each year shall be not less than five per cent of the original proceeds left with the Company.

The first instalment under Options 2 and 3 will be payable on the date when the proceeds of the Policy become due, and the instalment payment on each anniversary of the first payment will be increased by such additional interest, in excess of three per cent per annum, as the Company may declare on such funds for that year. The additional interest under Option 2 will be calculated on the unpaid instalments commuted at three per cent per annum, and under Option 3 on the unpaid instalments for the fixed period selected, commuted at three per cent per annum.

When the proceeds of the Policy become payable the Company will deliver to each payee a certificate evidencing the rights and benefits of such payee under the option selected.

At the death of any payee any unpaid sum left with the Company under Options 1, 4 or 5 with accrued interest to date of payment, or the commuted value at three per cent of any unpaid instalments under Option 2, or the commuted value at three per cent of any unpaid instalments for the fixed period selected under Option 3, will be paid in one sum to the executors or administrators of the payee, unless otherwise agreed in writing.

The Insured may direct in writing that the benefits under the above options shall not be transferable nor subject to commutation or incumbrance during the lifetime of the payee.

MONTHLY AND ANNUAL PAYMENTS FOR EACH $1,000 OF PROCEEDS OF POLICY

The semi-annual and quarterly instalments are 50.37% and 25.28% respectively of the annual instalment under Option 2, and not less than these respective percentages under Option 3.

OPTION 2			OPTION 3—LIFE INCOME TO PAYEE WITH INCOME GUARANTEED FOR													
			Age of Payee When Proceeds Become Payable	5 Years Certain		10 Years Certain		20 Years Certain		Age of Payee When Proceeds Become Payable	5 Years Certain		10 Years Certain		20 Years Certain	
Number of Years' Payments	Monthly Payment	Annual Payment		Monthly Payment	Annual Payment	Monthly Payment	Annual Payment	Monthly Payment	Annual Payment		Monthly Payment	Annual Payment	Monthly Payment	Annual Payment	Monthly Payment	Annual Payment
2	$42.86	$507.39	10 and under	$3.81	$44.85	$3.75	$44.21	$3.58	$42.20	48	$5.36	$62.61	$5.17	$60.51	$4.60	$54.20
3	28.99	343.23	11	3.83	45.07	3.77	44.41	3.59	42.56	49	5.45	63.63	5.24	61.40	4.65	54.71
4	22.06	261.19	12	3.85	45.30	3.79	44.62	3.61	42.54	50	5.54	64.70	5.32	62.33	4.69	55.24
5	17.91	211.99	13	3.87	45.54	3.81	44.84	3.62	42.71	51	5.64	65.83	5.41	63.30	4.74	55.77
6	15.14	179.22	14	3.89	45.78	3.83	45.07	3.64	42.90	52	5.74	67.02	5.49	64.30	4.78	56.30
7	13.16	155.83	15	3.91	46.03	3.85	45.29	3.65	43.08	53	5.85	68.26	5.58	65.35	4.83	56.84
8	11.68	138.30	16	3.94	46.27	3.87	45.53	3.67	43.27	54	5.97	69.57	5.68	66.44	4.87	57.37
9	10.53	124.69	17	3.96	46.52	3.89	45.76	3.69	43.47	55	6.09	70.95	5.78	67.57	4.92	57.90
10	9.61	113.81	18	3.98	46.77	3.91	45.99	3.70	43.66	56	6.22	72.40	5.88	68.75	4.96	58.43
11	8.86	104.92	19	4.00	47.02	3.93	46.23	3.72	43.87	57	6.35	73.93	5.98	69.98	5.00	58.95
12	8.24	97.53	20	4.02	47.28	3.95	46.48	3.74	44.07	58	6.49	75.53	6.09	71.24	5.05	59.46
13	7.71	91.29	21	4.05	47.55	3.97	46.74	3.76	44.29	59	6.64	77.22	6.21	72.55	5.09	59.96
14	7.26	85.94	22	4.07	47.84	4.00	47.01	3.78	44.52	60	6.80	78.99	6.32	73.94	5.13	60.45
15	6.87	81.32	23	4.10	48.14	4.02	47.29	3.80	44.75	61	6.96	80.85	6.44	75.31	5.17	60.92
16	6.53	77.29	24	4.12	48.45	4.05	47.59	3.82	45.00	62	7.13	82.81	6.57	76.75	5.20	61.37
17	6.23	73.74	25	4.15	48.77	4.07	47.90	3.84	45.25	63	7.31	84.87	6.70	78.23	5.24	61.80
18	5.96	70.59	26	4.18	49.12	4.10	48.22	3.86	45.51	64	7.51	87.03	6.83	79.75	5.27	62.20
19	5.73	67.78	27	4.21	49.47	4.13	48.56	3.89	45.79	65	7.71	89.31	6.96	81.30	5.30	62.59
20	5.51	65.25	28	4.25	49.85	4.16	48.91	3.91	46.07	66	7.92	91.69	7.09	82.89	5.33	62.94
21	5.32	62.98	29	4.28	50.24	4.19	49.28	3.94	46.37	67	8.14	94.19	7.23	84.50	5.36	63.27
22	5.15	60.91	30	4.32	50.65	4.23	49.66	3.96	46.67	68	8.37	96.81	7.37	86.14	5.38	63.57
23	4.99	59.04	31	4.35	51.08	4.26	50.07	3.99	46.99	69	8.61	99.56	7.51	87.79	5.40	63.84
24	4.84	57.32	32	4.39	51.53	4.30	50.49	4.02	47.32	70	8.86	102.43	7.65	89.46	5.42	64.08
25	4.71	55.75	33	4.43	52.01	4.33	50.93	4.05	47.66	71	9.13	105.44	7.79	91.12	5.44	64.29
26	4.59	54.30	34	4.48	52.50	4.37	51.39	4.08	48.01	72	9.40	108.57	7.93	92.79	5.45	64.48
27	4.47	52.97	35	4.52	53.02	4.42	51.87	4.11	48.36	73	9.69	111.84	8.07	94.44	5.47	64.64
28	4.37	51.76	36	4.57	53.56	4.46	52.38	4.14	48.75	74	9.99	115.25	8.21	96.06	5.48	64.77
29	4.27	50.59	37	4.62	54.13	4.51	52.90	4.17	49.14	75	10.30	118.78	8.34	97.65	5.48	64.88
30	4.18	49.53	38	4.67	54.73	4.55	53.45	4.21	49.54	76	10.62	122.44	8.47	99.21	5.49	64.97
			39	4.73	55.36	4.60	54.03	4.24	49.96	77	10.95	126.22	8.59	100.71	5.50	65.05
			40	4.78	56.02	4.65	54.63	4.28	50.38	78	11.29	130.13	8.71	102.14	5.50	65.11
			41	4.84	56.71	4.71	55.26	4.32	50.82	79	11.64	134.14	8.82	103.51	5.50	65.15
			42	4.91	57.43	4.77	55.91	4.35	51.27	80	12.00	138.25	8.92	104.80	5.51	65.19
			43	4.97	58.19	4.83	56.60	4.39	51.73	81	12.36	142.44	9.02	106.01	5.51	65.21
			44	5.04	58.99	4.89	57.31	4.43	52.20	82	12.73	146.70	9.11	107.12	5.51	65.23
			45	5.12	59.83	4.95	58.06	4.48	52.69	83	13.09	151.00	9.19	108.14	5.51	65.24
			46	5.19	60.71	5.02	58.84	4.52	53.18	84	13.46	155.34	9.26	109.06	5.51	65.25
			47	5.27	61.64	5.09	59.66	4.56	53.68	85 and over	13.83	159.67	9.32	109.89	5.51	65.25

LOAN VALUES

After three full years' premiums have been paid and before default in the payment of premium, the Company will advance to the Insured on the sole security of this Policy, as duly evidenced in writing, an amount which with interest shall not exceed the Cash Surrender Value. Interest on the loan will be at the rate of six per cent per annum payable annually on the anniversary of the Policy. If interest is not paid when due, it shall be added to the principal. All or any part of the indebtedness may be repaid at any time while the Policy is in force. Failure to repay such indebtedness or to pay interest will not avoid the Policy, but whenever the amount of the total indebtedness equals the Cash Surrender Value, the Policy shall become void one month after the Company shall have mailed notice to the last known address of the Insured and of the assignee of record, if any.

TABLE OF LOAN-VALUES FOR EACH $1,000 OF THE FACE AMOUNT

Years' Premiums Paid	Loan Value	Years' Premiums Paid	Loan Value
3	$40	15	$311
4	55	16	338
5	76	17	366
6	96	18	396
7	117	19	426
8	140	20	457
9	165	21ST YEAR	466
10	188	22ND "	475
11	212	23RD "	484
12	235	24TH "	494
13	260	25TH "	503
14	285		"

SURRENDER VALUES

In event of default in payment of premium after three full years' premiums have been paid, the following benefits shall apply:

(a) Temporary Insurance—Insurance for the face of the Policy plus any dividend additions and any dividend deposits and less the amount of any indebtedness hereon, shall, upon expiry of the period of grace, be continued automatically as Temporary Insurance as from the date of default for such term as the Cash Surrender Value less any indebtedness hereon will purchase as a net single premium at the attained age of the Insured, according to the American Table of Mortality and interest at 3 per cent. This Temporary Insurance will be without participation in surplus.

(b) Participating Paid-up Insurance—Within three months after such default, but not later, the insured may surrender this Policy and elect in place of such Temporary Insurance to have this Policy indorsed for the amount of Participating Paid-up Insurance which the Cash Surrender Value at date of default less any indebtedness hereon, will purchase as a net single premium at the attained age of the Insured at the date of default according to the American Table of Mortality and interest at 3 per cent. The Insured may obtain a loan on such Paid-up Insurance or surrender it within one month after any anniversary for its cash surrender value.

TABLE OF GUARANTEED SURRENDER VALUES

After Policy has been in force	Cash Surrender Value for each $1,000 of the Face Amount	Paid-up Life Insurance for each $1,000 of the Face Amount	Temporary Insurance from date of default	
			Years	Days
3	$43	$119	5	307
4	59	163	8	104
5	81	220	11	256
6	102	270	14	323
7	125	326	18	194
8	149	383	21	349
9	175	440	24	349
10	200	496	27	186
11	225	546	29	145
12	250	596	31	13
13	276	647	32	174
14	303	697	33	288
15	330	748	35	14
16	359	798	36	116
17	389	849	37	270
18	420	899	39	173
19	452	950	41	335
20	485	1000	..	...
21	495			
22	504	POLICY PAID-UP		
23	514	PARTICIPATING.		
24	524			
25 YRS.	534			

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Values for later years will be computed on the same basis and will be furnished on request

(c) Cash Surrender Value—If the Policy shall not have been indorsed for Participating Paid-up Insurance, the Insured, within three months after such default, but not later, may surrender this Policy and all claims thereunder and receive its Cash Surrender Value as at date of default less any indebtedness hereon. The Cash Surrender Value shall be the reserve on the face amount of the Policy at date of default, omitting fractions of a dollar per thousand of insurance, and the reserve on any outstanding dividend additions and any outstanding dividend deposits, and less a surrender charge for the third to the ninth years, inclusive, of not more than one and one-half per cent of the face of the Policy. The reserve shall be computed on the basis of the American Table of Mortality and interest at 3 per cent.

Cash Surrender Value of Fully Paid Policy—If this Policy shall have become fully paid by its terms, the Insured may surrender the Policy and all claims thereunder within one month after any anniversary of the policy and receive its cash surrender value less any indebtedness hereon. Such cash surrender value shall be computed on the basis described under (c) above.

The values in the "Table of Guaranteed Surrender Values" are computed in accordance with the above provisions, on the basis of $1,000 of face amount, assuming that premiums have been duly paid for the number of years stated, that there is no indebtedness to the Company, that there are no outstanding dividend additions nor dividend deposits, and after deduction of the surrender charge, if any.

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2551-4

TERM INSURANCE IN CASE OF LOAN

Any loan under this Policy may be covered by term insurance as follows:

1. The Insured must furnish evidence of insurability satisfactory to the Company.
2. The premium shall be computed at the attained age of the Insured at the time the term insurance is made or renewed.
3. Term insurance shall not extend beyond the next anniversary, but under the same conditions may be renewed from year to year. No term insurance shall be made or renewed after age sixty-five.
4. If the term insurance exceeds the indebtedness, the Company may cancel the excess and refund the unearned premium.
5. Term insurance takes effect upon delivery to the Insured of the Company's Policy therefor. The sum payable as term insurance shall be applied to the cancelation of the indebtedness.

PREMIUMS FOR EACH $100 OF TERM INSURANCE

Insured's Attained Age	Premium for One Year	Insured's Attained Age	Premium for One Year	Insured's Attained Age	Premium for One Year	Insured's Attained Age	Premium for One Year
15	$0.72	28	$0.79	41	$0.96	54	$1.67
16	0.74	29	0.80	42	0.99	55	1.79
17	0.74	30	0.81	43	1.01	56	1.91
18	0.74	31	0.82	44	1.04	57	2.08
19	0.75	32	0.83	45	1.07	58	2.31
20	0.75	33	0.84	46	1.11	59	2.58
21	0.76	34	0.85	47	1.15	60	2.87
22	0.76	35	0.86	48	1.20	61	3.18
23	0.77	36	0.87	49	1.24	62	3.61
24	0.77	37	0.89	50	1.33	63	3.96
25	0.78	38	0.90	51	1.46	64	3.66
26	0.78	39	0.92	52	1.46		
27	0.79	40	0.94	53	1.57		

For periods of less than one year, the premium shall be at the rate of one-tenth of the one year's premium for each month and fraction of a month

OTHER PROVISIONS

Age.—If the age of the Insured has been misstated, the amount payable hereunder shall be such as the premium paid would have purchased at the correct age.

Payment of Premiums.—All premiums are payable on or before their due date at the Home Office of the Company or to an authorized agent of the Company, but only in exchange for the Company's official premium receipt signed by the President, a Vice-President, a Second Vice-President, a Secretary or the Treasurer of the Company, and countersigned by the person receiving the premium. No person has any authority to collect a premium unless he then holds said official premium receipt. The premium may be made payable annually, semi-annually or quarterly in advance at the Company's respective rates for such modes of payment and the mode of payment may be changed by agreement in writing and not otherwise. The payment of the premium shall not maintain the Policy in force beyond the date when the next payment becomes due, except as to the benefits provided for herein after default in premium payment.

Indebtedness.—Any indebtedness to the Company against this Policy will be deducted in any settlement thereof.

Self-Destruction.—In event of self-destruction during the first two insurance years, whether the Insured be sane or insane, the insurance under this Policy shall be a sum equal to the premiums thereon which have been paid to and received by the Company and no more.

The Contract.—The Policy and the application therefor, copy of which is attached hereto, constitute the entire contract. All statements made by the Insured shall, in absence of fraud, be deemed representations and not warrantics, and no statement shall avoid the Policy or be used in defense to a claim under it, unless it is contained in the written application and a copy of the application is indorsed upon or attached to this Policy when issued. No agent is authorized to make or modify this contract, or to extend the time for the payment of premium, or to waive any lapse or forfeiture or any of the Company's rights or requirements. All benefits under this Policy are payable at the Home Office of the Company in the City and State of New York.

Incontestability.—This Policy shall be incontestable after two years from its date of issue except for non-payment of premium and except as to provisions and conditions relating to Disability and Double Indemnity Benefits.

REGISTER OF CHANGE OF BENEFICIARY

NOTE.—NO CHANGE OF BENEFICIARY SHALL TAKE EFFECT UNLESS INDORSED ON THIS POLICY BY THE COMPANY AT THE HOME OFFICE

DATE OF REQUEST	BENEFICIARY	INDORSED BY

31-32

9 727-569

APPLICATION TO THE NEW YORK LIFE INSURANCE COMPANY—Part I.

I, Demetrios P. Vigias
(Print name in full)

Residence	Place of Business	Present Occupation	Born at
State Mass	Mass	Counter man	Pindasistes
County Suffolk	Suffolk	State exact duties in full	Asia Minor
Town Boston	Boston		on 15 day of Jan. 1904
Street Tremont St. Hungtington ave.	305	Other Occupations (if any)	Race or nationality Greek
No. 430 R.F.D.			Not married (Strike out one)
Name of firm or employer Excelsior Lunch			Send all communications to Residence / Place of Business (Strike out one)
Former residence* 346 Tremont St.	Former place of business*		Former firm or employer* Excelsior Lunch

Cornerstone Application

APPLY TO THE NEW YORK LIFE INSURANCE COMPANY FOR INSURANCE AS FOLLOWS:

2. Sum to be insured, $ 3000 — The Sum is payable [illegible] Demetrios P. Vigias — Age nearest birthday 23

3. Plan of Insurance 20 payment life — Date of this application / Date Policy is written (Strike out one)

4. Dividend to be { a Paid in cash; b Applied to purchase additional paid-up insurance; c Applied to purchase additional paid-up insurance; d Left to accumulate at interest, subject to my order; e Applied on the Accelerative Endowment plan. (Strike out four)

NOTE.—Option e applies only to Endowment policies containing the Accelerative Endowment option.

5. I designate as Beneficiary to receive the proceeds of policy in event of death, and reserve the right to change the Beneficiary from time to time,
Beneficiary (Print name in full) Panagiotis P. Papaioannou Legal
Who resides at Pindasistes Asia Minor Relationship to me my legal heir

6. a The following is all the insurances I now have on my life:
State name of Company and Amount (If none, say none) None
b The insurance for which I am now applying is not intended to take the place of insurance carried with this or any other Company. If so, give particulars: None

7. Of the insurances on my life the amount which includes benefits in event of total disability is $ None (If none, say none)

8. No Company has declined to issue insurance on my life [illegible] insured or offered to issue insurance on my life differing from the insurance applied for, except as follows: (If none, say none) None

9. ADDITIONS OR AMENDMENTS. (For Home Office use only)

(211) Rate inserted $ 20.22

It is mutually agreed as follows: 1. That the insurance hereby applied for shall not take effect unless and until the policy is delivered to and received by the applicant and the first premium thereon paid in full during his lifetime, and then only if the applicant has not consulted or been treated by any physician since his medical examination; provided, however, that if the applicant, at the time of making this application, pays the agent in cash the full amount of the first premium for the insurance applied for in Questions 2 and 3 and so declares in this application and receives from the agent a receipt therefor on the receipt form which is attached hereto, and if the Company, after medical examination and investigation, shall be satisfied that the applicant was, at the time of making this application, insurable and entitled under the Company's rules and standards to the insurance, on the plan and for the amount applied for in Questions 2 and 3, at the Company's published premium rate corresponding to the applicant's age, then said insurance shall take effect and be in force under and subject to the provisions of the policy applied for from and after the time this application is made, whether the policy be delivered to and received by the applicant or not. 2. That a receipt on the form attached as a coupon to this application form is the only receipt the agent is authorized to give for any payment made before the delivery of the policy. 3. That only the President, a Vice-President, a Second Vice-President, a Secretary or the Treasurer of the Company can make, modify or discharge contracts, or waive any of the Company's rights or requirements; that notice to or knowledge of the soliciting agent or the Medical Examiner is not notice to or knowledge of the Company, and that neither one of them is authorized to accept risks or to pass upon insurability. 4. That by receiving and accepting said policy, any additions or amendments hereto which the Company may make and refer to in Question 9 above entitled "Additions or Amendments" are hereby ratified.

Dated at Boston this 21 day of Janu. 1921 Demetrios P. Vigias
Witnessed by Christ N. Katsaros Agent. Signature of the person applying for insurance
(Write the name in full)

Other Agents
Names and Residences of three intimate friends.

DECLARATION TO BE SIGNED BY APPLICANT UPON MAKING ANY PAYMENT WITH THIS APPLICATION.

Dated at Janu. 21 1921

I Hereby Declare that I have paid to Christ N. Katsaros
First — Dollars ($ .50) in cash,
and that I hold his receipt for the same, made up, without alteration, on the receipt form detached from and corresponding in date and number with this application. I assent to the terms of said receipt.

(Signature of Applicant)
THIS CITY HERE Demetrios P. Vigias

No. 807223

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COPY OF APPLICATION

Application to the New York Life Insurance Company—PART II 2727 - 569

ANSWERS TO THE MEDICAL EXAMINER

THIS EXAMINATION MUST BE MADE IN PRIVATE; NO AGENT OR THIRD PERSON BEING PRESENT

NOTICE TO MEDICAL EXAMINER: Use only black ink. This examination is to be photographed

DO NOT USE DASHES OR DITTO MARKS IN ANSWERING QUESTIONS

1. A. What is your occupation? (*Full details.*) — A. Waila
   B. How long have you been engaged in your present occupation? — B.
   C. What was your previous occupation? — C. Glass Weaver
   D. Have you ever changed your occupation or place of residence on account of your health? (*If so, give full details.*) — D. No

2. Do you intend to change your occupation or make a journey outside of Continental United States or Canada? (*If so, give full details.*) — No

3. A. How many aerial flights have you taken and when last? — A.
   B. State whether as passenger or pilot and whether you are a Reservist. — B. Never

4. In what States have you lived the last ten years, and which years in each? (*If outside the U. S., in what countries, and which years in each.*) — Mass 4 yrs N.H. 2 yrs. Germany Greece

5. A. How frequently, if at all, and in what quantity do you drink beer, wine, spirits or other intoxicants? — A. Occasionally
   B. How frequently, if at all, and in what quantity have you drunk any of them in the past? — B.
   C. Have you within the last five years drunk any of them to excess? — C. Never
   D. Do you now take or have you ever taken morphine, cocaine, or any other habit forming drugs? — D. —

		"Yes" or "No"	Name of each Company or Insurer.
6. A.	Have you now pending any other application for insurance on your life or for the reinstatement of insurance?	No	
B.	Have you ever been examined either on or in anticipation of an application for insurance without receiving such insurance?	No	
C.	Have you ever been declined for life insurance or for the reinstatement of life insurance?	No	
D.	Have you ever been offered a policy differing in plan or amount or in premium rate from that applied for?	No	

		"Yes" or "No"	If the answer to any query is "Yes" give DETAILS and, if within five years, name and address of every Physician consulted.
7. A.	Have you had any accident or injury or undergone any surgical operation?	No	
B.	Have you been under observation or treatment in any hospital, asylum or sanitarium?	No	
C.	Has albumin or sugar been found in your urine?	No	
D.	Have you been found to have a high blood pressure?	No	
E.	Have you raised or spat blood?	No	
F.	Have you gained or lost in weight in the last year?	No	Gain? Loss? Cause?

		"Yes" or "No"	Name of Ailment or Disease	No. of Attacks	Date	Duration	Severity	Remarks and, if within five years, name and address of every Physician consulted
8.	Have you consulted a physician for or suffered from any ailment or disease of							
A.	The Brain or Nervous System?	No						
B.	The Heart, Blood Vessels or Lungs?	No						
C.	The Stomach or Intestines, Liver, Kidneys or Bladder?	No						
D.	The Skin, Middle Ear or Eyes?	No						
9.	Have you had Rheumatism, Gout or Syphilis?	No						
10.	Have you consulted a physician for any ailment or disease not included in your above answers?	No						

		Name and Address	Date	Reason for Consultation, Examination or Treatment
11.	What physician or physicians, if any, not named above, have you consulted or been examined or treated by within the past five years?	—		

(*If none, say none.*)

12. Family Record	Age if Living	Condition of Health, if not good, give full details	Age at Death	Cause of Death	How Long Ill
Father	60	Good			
Mother	55	"			
Brothers 3	25	"			
	27	"			
1	23	"			
	35	"			
Sisters 2	21	"			

13. A. Is any person in your immediate household now ill with consumption? (*If so, state who and what precautions are being taken.*) — No

B. Has any person in your immediate household suffered from or died of that disease within the past year? — No

On behalf of myself and of every person who shall have or claim any interest in any insurance made hereunder, I declare that I have carefully read each and all of the above answers, that they are each written as made by me, and that each of them is full, complete and true, and agree that the Company believing them to be true shall rely and act upon them.

I expressly waive, on behalf of myself and of any person who shall have or claim any interest in any policy issued hereunder, all provisions of law forbidding any physician or other person who has heretofore attended or examined me, or who may hereafter attend or examine me, from disclosing any knowledge or information which he thereby acquired.

Dated this 2 day of [illegible] 1921

Witnessed by [illegible] M. D., Medical Examiner. Signature of the person applying for insurance: Demetrios P. Vagis

NOTE

This copy should be carefully examined and if any error or omission is found, full particulars, with the number of the policy, should be sent immediately to the Home Office of the Company, No. 51 Madison Avenue, Madison Square, New York, N. Y.

35-36

"EXHIBIT A"

5790 Law

NEW YORK LIFE INSURANCE COMPANY

DEMETRIOS P. VIGLAS

No. 9 727 569

Amount $ 2000

SEMI Annual Premium $ 38.00

Payable on the 7TH day of FEBRUARY AND AUGUST

NEW ENGLAND Branch

Notice: It is not necessary for the Insured or the Beneficiary to employ the agency of any person in collecting the insurance under this Policy, or in receiving any of its benefits. Time and expense will be saved by writing direct to the Home Office, 51 Madison Avenue, Madison Square, New York, N. Y.

Insurance payable at death.

Premiums payable for 20 years unless dividends applied to shorten premium paying period.

Disability Benefits providing for increasing monthly income.

Double Indemnity for fatal accident.

Annual Participation in Surplus.

925-62

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INDORSEMENTS

In accordance with Provision 9 of Section 132 of Chapter 175 of the General Laws of the Commonwealth of Massachusetts, granting loans (except for the purpose of paying premiums on policies in the Company) or the payment of the Cash Surrender Value may be deferred for not exceeding ninety days after application therefor is made.

(914-22.)

Secretary

[fol. 39] Clerk's certificate to foregoing transcript omitted in printing.

[fol. 40] SUPREME COURT OF THE UNITED STATES

ORDER ALLOWING CERTIORARI—Filed December 23, 1935

The petition herein for a writ of certiorari to the United States Circuit Court of Appeals for the First Circuit is granted. And it is further ordered that the duly certified copy of the transcript of the proceedings below which accompanied the petition shall be treated as though filed in response to such writ.

Endorsed on cover: File No. 40,156. U. S. Circuit Court of Appeals, First Circuit. Term No. 602. New York Life Insurance Company, petitioner, vs. Demetrios P. Viglas. Petition for writ of certiorari and exhibit thereto. Filed November 23, 1935. Term No. 602, O. T., 1935.

(7296-C)

Office Supreme Court, U. S.
FILED
NOV 23 1935
CHARLES ELMORE CROPLEY
CLERK

FILE COPY

In the

Supreme Court of the United States.

October Term, 1935.

No. 602

New York Life Insurance Company,

Petitioner,

v.

Demetrios P. Viglas,

Respondent.

Petition for a Writ of Certiorari to the Circuit Court of Appeals for the First Circuit

and

Brief in Support Thereof.

LOUIS H. COOKE,
New York,
F. H. NASH,
C. R. BRANCH,
Boston,
Attorneys for Petitioner.

ADDISON C. GETCHELL & SON, LAW PRINTERS, BOSTON.

In the

Supreme Court of the United States.

OCTOBER TERM, 1935.

No.

NEW YORK LIFE INSURANCE COMPANY,

PETITIONER,

v.

DEMETRIOS P. VIGLAS,

RESPONDENT.

PETITION FOR A WRIT OF CERTIORARI TO THE CIRCUIT COURT OF APPEALS FOR THE FIRST CIRCUIT.

To the Honourable the Justices of the Supreme Court of the United States:

The undersigned, on behalf of New York Life Insurance Company, the above-named petitioner, pray that a writ of certiorari may issue to review the judgment of the Circuit Court of Appeals for the First Circuit entered July 13, 1935, in the case between the above-named parties docketed in that Court as number 3012.

OPINIONS BELOW.

An opinion entitled "Memorandum" was filed November 22, 1934, by Judge McLellan of the District Court. It has not been reported. It is found on pages 9 and 10 of the

record. The opinion of the Circuit Court of Appeals (delivered by Judge Morton) is printed at pages 13-19 of the record and is reported 78 F. (2d) 829.

Jurisdiction.

The judgment of the Circuit Court of Appeals was entered July 13, 1935 (R. 20). A petition for rehearing was filed in said Court August 6, 1935, and was denied October 9, 1935 (R. 20).

The jurisdiction of this Court is invoked under section 240 (a) of the Judicial Code as amended, U.S.C. Title 28, section 347.

The jurisdiction of the District Court over the case (which was commenced by a writ returnable to the District Court for the District of Massachusetts) was asserted by the respondent (the plaintiff) by reason of the fact that the respondent is a citizen and resident of Massachusetts and the petitioner a citizen of New York, and, as alleged, that the amount in controversy exceeded $3000 exclusive of interest and costs (U.S.C. Title 28, section 41 (1)). This jurisdiction is challenged by the petitioner.

Question Presented.

The question presented is that considered by this Court in the case of *Mobley* v. *New York Life Insurance Company*, October Term 1934, No. 751, 79 L. Ed. 936 (which was not followed by the Circuit Court of Appeals):

Whether the holder of a life insurance policy promising him monthly payments and waiver of premiums in the event that he becomes totally and permanently disabled and providing for cessation of these benefits if he ceases to be disabled may recover as damages the present value of those payments for the balance of his life expectancy and the

present value of the face of the policy when he asserts that he is so totally and permanently disabled but this is denied by the insurer, which upon his subsequent failure to pay a premium declares the policy lapsed.

The Travel of the Case and its Facts.

The case comes up upon petitioner's demurrer to the respondent's substitute declaration in an action at law. The writ was dated November 9, 1933, and its ad damnum was $15,000, subsequently (by amendment) increased to $20,000 (R. 2, 3).

The substitute declaration (R. 3-7) is based upon a life insurance policy issued by the petitioner to the respondent (R. 21). Under this policy the petitioner undertook to pay the beneficiaries (who are not parties to the litigation) $2000 upon the death of the respondent, and "upon receipt of due proof that the Insured is totally and presumably permanently disabled" (R. 23) to pay to the respondent himself $20 per month throughout the continuance of the disability and to waive payment of premiums (otherwise payable semi-annually) by the respondent throughout the same period. Careful provisions were in the policy covering this obligation (R. 23). The promise is to pay the monthly annuity "for each completed month from the commencement of and during the period of continuous total disability" and to waive premiums "falling due during the period of continuous total disability" (R. 23). Before making payments (subject to certain conditions not presently material) the petitioner might require proof of the continuance of the disability, and there was a provision expressly terminating the respondent's right to receive these benefits unless it should appear that the disability was still continuing.

The substitute declaration contains two counts. Under the first, recovery of only $1408 is sought, so it may be dis-

regarded. In the second it is alleged that on September 11, 1931, the respondent "became totally and permanently disabled within the terms and provisions of the contract," and that thereupon the petitioner honoured the claim made, paid the $20 monthly annuity to and including July 11, 1933, and waived premimus falling due prior to August 7, 1933. It is then alleged—

> ". . . that on or about September 1, 1933, the defendant refused to make the monthly payment due August 11, 1933, and refused to waive the semi-annual premium due August 7, 1933, asserting to the plaintiff as its ground for such refusal that since it appeared to the defendant that for some time past the plaintiff had not been continuously totally disabled within the meaning of the disability benefit provision of the policy, the defendant would make no further monthly disability payments, and that the premiums due on and after August 7, 1933, would be payable in conformity with the terms of the contract. Upon the expiration of the days of grace after August 7, 1933, for the payment of the semi-annual premium, the defendant on or about September 19, 1933, declared the policy as lapsed upon its records, the premiums not having been waived by the defendant nor paid by the plaintiff" (R. 6).

This is followed by an allegation that the respondent was in fact totally disabled throughout, and consequently that the refusal of the benefits was a breach by the petitioner and that the respondent "elected to treat said wrongful refusal of the defendant [petitioner] to perform its obligations under said contract as a repudiation and renunciation of the entire contract" (R. 6, 7). Upon this basis entire damages were sought, based upon the respondent's life expectancy and his anticipation that he would remain disabled, amounting to some $15,900.

To this declaration the petitioner demurred (R. 8) upon the ground that the allegations did not show a total breach and that the limit of the recovery on the allegations was the amount of accrued monthly payments and waiver of premium, amounting in all to $98, and so far below the jurisdictional requirement of more than $3000. As far as the demurrer is concerned, there has never been any dispute on the figures. The only question presented was whether the allegations showed such a breach as to allow recovery of damages which should include future indemnity which might or might not become payable depending upon future facts which could not be prophesied with any exactness.

The District Court answered this question in the negative and sustained the demurrer (R. 9, 10). In support of the declaration the respondent relied heavily on the case of *Federal Life Insurance Company* v. *Rascoe,* 12 F. (2d) 693 (C.C.A. 6). The District Court treated that case as such authority, but refused to follow it, on the ground that it was contrary to the weight of authority.

On the respondent's appeal to the Circuit Court of Appeals he took the same position and based his argument upon the authority of the *Rascoe* case. The argument took place before *Mobley* v. *New York Life Insurance Company* was argued in this Court. The opinion was handed down after the decision of this Court in the *Mobley* case and after counsel by letter to the clerk had called the attention of the Court to that decision. In the opinion (written by Judge Morton) it was held that the allegations showed a total breach and repudiation of the policy which entitled the respondent to the entire damages which he sought. The *Rascoe* case was not mentioned, and an attempt was made to distinguish the *Mobley* case.

The petitioner seasonably petitioned for a rehearing. This was denied without opinion.

Specification of Errors.

The Circuit Court of Appeals erred—

(1) In refusing to follow the decision of this Court in *Mobley* v. *New York Life Insurance Company,* 79 L. Ed. 936.

(2) In holding that the declaration showed a repudiation of its contract by the petitioner upon allegations, without more, that (*a*) the respondent was entitled to continue to receive disability benefits from the petitioner, but that (*b*) the petitioner refused to continue the benefits upon the ground (not alleged to have been taken *mala fide*) that the respondent had not met the conditions upon which only the benefits were payable, and (*c*) thereafter upon failure to receive a premium declared the policy lapsed.

(3) In ruling that, upon a total breach of a policy providing for monthly future payments conditioned upon the state of health of the policyholder at the beginning of each future month, the present value of those future payments, computed upon the assumption that the policyholders will live out the normal expectancy of an unimpaired life and continue to suffer total disability, may be recovered.

(4) In reversing the judgment of the District Court and ordering the petitioner's demurrer to the substitute declaration overruled.

Reasons for Granting the Writ.

(1) The Circuit Court of Appeals refused to follow the decision of this Court in the *Mobley* case. It was aware of the decision and sought to distinguish it.

The pertinent facts stated in this Court's opinion relied on as showing a total breach in the *Mobley* case were (79 L. Ed. 938):

> "March 1, 1933 the company wrote him stating it appeared that for some time he had not been continuously disabled within the meaning of the policies, that no further monthly payments could be made and that the premiums due on and after February 7 became payable according to the terms of the contracts . . .
>
> "April 13 it notified plaintiff that the $5000 policy had lapsed . . ."

It was held that these facts did not show a repudiation of the policy.

The pertinent and parallel allegations in the instant case are that the petitioner refused to continue benefits—

> "asserting to the plaintiff as its [petitioner's] ground for such refusal that since it appeared to the defendant that for some time past the plaintiff had not been continuously totally disabled within the meaning of the disability benefit provision of the policy, the defendant would make no further monthly disability payments, and that the premiums due on and after August 7, 1933 would be payable in conformity with the terms of the contract"—

and that upon non-payment of the August 7 premium the petitioner—

> "declared the policy as lapsed upon its records" (R. 6).

The policy provisions in the two cases were substantially identical (R. p. 23; 79 L. Ed. 937).

In spite of this parallel the Court here construed these allegations to show a repudiation of the policy, and said:

> "The facts alleged are essentially different from those in the Mobley case . . ." (R. 17).

(2) If there be any ground for distinction between this case and the *Mobley* case and the allegations do show repudiation, which we emphatically deny, this case then squarely presents the question of "whether the doctrine of anticipatory breach is applicable to the class of cases to which this one belongs," which was left open by this Court in its opinion in the *Mobley* case (79 L. Ed. 939).

The question is an important one. It has never been passed upon by this Court.

(3) The points raised are of great interest and importance. That damages like those sought here might be recovered was announced for the first time in 1926 in the majority opinion in *Federal Life Ins. Co.* v. *Rascoe,* 12 F. (2d) 693 (C.C.A. 6). Since then no effort has been spared to demonstrate the unsoundness of the majority opinion in the *Rascoe* case and to obtain an authoritative decision demonstrating that unsoundness. It was thought that those efforts had been successful when this Court announced its opinion in the *Mobley* case. The opinion of the Circuit Court of Appeals in the instant case, following the *Mobley* opinion by a scant two months, now makes the situation more confused than ever. That confusion would be resolved by a decision by this Court in the instant case.

Moreover, an important point of federal jurisdiction is involved. Actions to recover disability benefits are very common. In probably a great majority of these actions there is diversity of citizenship. In certainly an overwhelming majority the amounts of the accrued disability payments are far below $3000. In most of them the plaintiff could make allegations essentially identical with those made here by the respondent. Those allegations are printed in the Federal Reporter. Consequently it is probable that every such case arising in the future will find its way into the Federal Courts.

Such a situation merits the attention of this Court.

(4) The decision is *contra* to that of the Circuit Court of Appeals for the Tenth Circuit in—

Kimel v. *Missouri State Life Insurance Co.*, 71 F. (2d) 921.

Wherefore it is respectfully submitted that this petition should be granted.

LOUIS H. COOKE,
New York,
F. H. NASH,
C. R. BRANCH,
Boston,
Attorneys for Petitioner.

In the

Supreme Court of the United States.

October Term, 1935.

No.

NEW YORK LIFE INSURANCE COMPANY,

PETITIONER,

v.

DEMETRIOS P. VIGLAS,

RESPONDENT.

BRIEF IN SUPPORT OF PETITION FOR A WRIT OF CERTIORARI TO THE CIRCUIT COURT OF APPEALS FOR THE FIRST CIRCUIT.

The facts are stated in the petition in support of which this brief is filed.

1. The Circuit Court of Appeals refused to follow the decision of this Court in Mobley v. New York Life Insurance Company, 79 L. Ed. 936.

The precise question presented upon the present record was before this Court in the case of *Mobley* v. *New York Life Insurance Company.* It will be observed that the insurer was the same in that case as in the instant case. The statement of the policy provisions contained in the opinion of the *Mobley* case indicates that the provisions relating to total and permanent disability there in suit were precisely the same as those in the policy in the case at bar. The pol-

icy provisions in the instant case cannot be described more succinctly than by following the language of the Court in that opinion. The policy provides:

> "That whenever the insured is so disabled by bodily injury or disease that he is wholly prevented from performing any work, following any occupation or engaging in any business for remuneration and the company receives proof that this disability will continue for life or that it has existed for the three months next preceding the proof, the company will pay monthly ten dollars per thousand of face value and waive premiums; that, before making any income payment or waiving any premium, the company may demand proof of continuance of total disability (but not oftener than once a year after disability has continued for two full years) and that, upon failure to furnish such proof, no further payments will be made nor premiums waived" (79 L. Ed. 937).

Mobley became disabled under circumstances which entitled him to receive the monthly payments provided in the policy. Thereafter a dispute arose between him and the insurer as to whether his disability was still persisting, and this Court stated:

> "March 1, 1933, the company wrote him stating it appeared that for some time he had not been continuously disabled within the meaning of the policies, that no further monthly payments would be made and that the premiums due on and after February 7 became payable according to the terms of the contracts" (79 L. Ed. 938).

Mobley immediately seized upon this notification as constituting a total breach of the policy which would entitle

him to recover at that time indemnity for a further period figured upon the theory that he would continue disabled and would live out his normal expectancy. The District Court for the Southern District of Mississippi, the Circuit Court of Appeals for the Fifth Circuit, and this Court all ruled that there could be no such recovery. This Court said in its opinion:

> "The evidence gives no support to the claim that it disregarded or intended to break its promises. We conclude that, as found by the lower courts—rightly declining to follow the decision of the Circuit Court of Appeals for the Sixth Circuit in Federal L. Ins. Co. v. Rascoe, supra (12 F. (2d) 696)—the company did not repudiate the policies. In view of that fact, we need not and therefore do not decide whether the doctrine of anticipatory breach is applicable to the class of cases to which this one belongs. Dingley v. Oler, 117 U. S. 490, 29 L. ed. 984, 6 S. Ct. 850, ubi supra" (79 L. Ed. 939).

In the case at bar the respondent became disabled under circumstances which led the petitioner to make monthly payments to him under his policy. The petitioner received advices that his condition had improved and refused to continue the payments. He brought suit, making the precise claim which Mobley had made. In his declaration he alleged—

> ". . . that on or about September 1, 1933, the defendant refused to make the monthly payment due August 11, 1933, and refused to waive the semi-annual premium due August 7, 1933, asserting to the plaintiff as its ground for such refusal that since it appeared to the defendant that for some time past the plaintiff had not been continuously totally disabled within the meaning of the disability benefit provision of the policy, the

> defendant would make no further monthly disability payments, and that the premiums due on and after August 7, 1933, would be payable in conformity with the terms of the contract'' (R. p. 6).

The District Court on demurrer ruled that this did not show a total breach which would support the action. The Circuit Court of Appeals held otherwise.

Obviously no distinction can be drawn between these allegations of the respondent's declaration and the evidence tending to show breach summarized by this Court in the *Mobley* case.

The Circuit Court of Appeals referred to the opinion of this Court in the *Mobley* case, but did not make any attempt to distinguish specifically between the allegations of the declaration which was before it and the facts on which this Court passed in the cited case. It contented itself with quotations from the opinion of this Court, laying down the broad general propositions of the law upon which such cases must depend and with the bare statement: ''The facts alleged are essentially different from those in the Mobley case where it was held that the evidence did not show repudiation of the policy or a complete denial of liability on it by the company'' (R. p. 17).

That statement is demonstrably not so. A comparison of the allegations of the breach in the respondent's declaration with the quotation from the opinion of this Court given above shows that there is no essential difference and indeed that both employ almost identical words. This is not extraordinary in view of the fact that both obviously were taken from the same form letter sent in such cases by New York Life Insurance Company to policyholders making claims like those of Mobley and the respondent.

The Circuit Court of Appeals made a point of the further allegation contained in the declaration that the peti-

tioner had declared the policy lapsed upon its records. The allegation of the declaration on this point was as follows:

> "Upon the expiration of the days of grace after August 7, 1933, for the payment of the semi-annual premium, the defendant, on or about September 19, 1933, declared the policy as lapsed upon its records, the premiums not having been waived by the defendant nor paid by the plaintiff" (R. p. 6).

Referring to this allegation the Circuit Court of Appeals said:

> "As we construe the declaration it alleges a complete and unqualified denial by the defendant of all liability on the policy. It states that the defendant not only refused to pay benefits due but wrongfully lapsed the policy for non-payment of premiums. An unconditional lapsing of the policy was a complete termination of it and a denial by the defendant of any further liability on it. There is no allegation that the defendant recognizes any further rights of the plaintiff in the policy, or any further liability upon it. . . . On the allegations of the declaration we are of opinion that the plaintiff was entitled to maintain the action and, if the lapsing was found to be a complete and unqualified denial by the defendant of any further liability on the policy and was unjustified that the plaintiff would be entitled to recover damages equivalent to the value to him of the contract which was broken" (R. pp. 16, 17).

But this allegation in no way distinguishes the instant case from the *Mobley* case. There also the insurer declared the policy lapsed. In both cases the company was simply referring to the express provision contained in the policies

that the policy should not remain in force beyond the date when the next premium payment should become due. It is only by a clear misconstruction of the allegations of the declaration that it is possible to say that they show "a complete and unqualified denial . . . of all liability on the policy." The notification of September 1, 1933, specifically stated that it was sent upon the ground, not that there was anything wrong with the policy, but that the respondent was not then continuously totally disabled, and it was coupled with a statement that the premiums due thereafter would be payable "in conformity with the terms of the contract"—thus specifically recognizing that the policy was then still in force.

The further notification that the policy had lapsed, sent after the time for the payment of the premium had passed, added nothing to the situation. If the premium was in fact payable, it was a simple notification that the policy had expired by its own terms. If, on the other hand, the premium should have been waived, it was entirely nugatory, added nothing to what had already gone before, and cannot be taken to indicate any intention on the part of the petitioner not to recognize its policy obligations. The situation in this respect is no different from a case where a premium has in fact been paid but through a clerical mistake the insurer does not realize the fact and advises the policyholder that the policy has lapsed. By no stretch of the imagination could such an advice be considered a breach of the provisions of the policy.

The fact that it appeared in evidence in the *Mobley* case that after the insurer had refused to continue benefits and had notified Mobley of the lapse of its policy it reversed its decision and tendered benefits to Mobley, which were refused, forms the basis for no distinction between the two cases. Mobley brought his action on the basis that there had then accrued to him a complete cause of action to re-

cover the entire amount sought, and that nothing done thereafter by the defendant could change the situation. It was on this basis that the case was decided. The behaviour of the insurer after the action was commenced was pertinent on the question of whether the original refusal to continue the benefits was made in good faith or not. In the present case this issue is not presented, since there are no allegations in the declaration that the petitioner did not act in good faith and the asserted ground of its action was one which was clearly open to it entirely irrespective of whether it may have been wrong in its understanding of the factual situation.

There are no allegations in the declaration that the petitioner took its position in anything other than entire good faith or that it disregarded or intended to break its promises. The attempted distinction of the two cases by the Circuit Court of Appeals has not even a superficial plausibility. There can be no escape from the conclusion that the Circuit Court of Appeals deliberately refused to follow the opinion of this Court.

2. The question of "whether the doctrine of anticipatory breach is applicable to the class of cases to which this one belongs" merits the consideration and opinion of this Court.

The substitute declaration contains an allegation that after petitioner had notified respondent that the policy had lapsed he "elected to treat said wrongful refusal of the defendant to perform its obligations under said contract as a repudiation and renunciation of the entire contract" (R. 6, 7). This obviously was included with a view to establishing a cause of action based upon an anticipatory breach. The Circuit Court of Appeals held that the doctrine of an-

ticipatory breach had nothing to do with the case (R. 17). We agree that that doctrine cannot apply, but we also submit that, unless it can apply, the respondent could not recover enough to meet the jurisdictional requirement, whatever the allegations showing breach.

Unless the breach amounted to an unequivocal refusal under any circumstances ever to pay the respondent anything further under the policy no question of the recovery of entire damages can arise on a theory either of present breach or of anticipatory breach. We believe we have demonstrated that the allegations do not show an unequivocal refusal any more than the facts in the *Mobley* case did. If, however, there is some ground for distinction which our industry has been unable to disclose, then the question of anticipatory breach becomes important and the statement of the Circuit Court of Appeals that it had nothing to do with the case becomes erroneous when taken with its order overruling the demurrer.

The doctrine of anticipatory breach is that, where one party to a contract containing mutual executory obligations before the time for his performance repudiates, the other may immediately recover damages for the non-performance of the future obligation.

See *Roehm* v. *Horst,* 178 U.S. 1.
Daniels v. *Newton,* 114 Mass. 530.
Parker v. *Russell,* 133 Mass. 74.

It was upon the theory that this doctrine applied to a case where an insurer refuses to continue disability payments that damages such as those sought by the respondent were first awarded.

Federal Life Insurance Co. v. *Rascoe,* 12 F. (2d) 693 (C.C.A. 6).

And later federal cases discussing the point put it upon that footing

Kimel v. *Missouri State Life Insurance Co.*, 71 F. (2d) 921 (C.C.A. 10).

Menssen v. *Travelers Ins. Co.*, 5 Fed. Supp. 11 (E.D. N.Y.).

Kithcart v. *Metropolitan Life Insurance Co.*, 1 Fed. Supp. 719 (N.D. Mo.).

Wyll v. *Pacific Mutual Life Insurance Co.*, 3 Fed. Supp. 483 (N.D. Tex.).

Hines v. *Fidelity Mutual Life*, 6 Fed. Supp. 692 (E.D. N.Y. 1934).

That is the only footing upon which it can be considered.

The obligation in these cases is not one single continuing one already accrued to make periodic payments for an indeterminate time. The Circuit Court of Appeals construed it in that way, and on the authority of *Pierce* v. *Tenn. &c. R.R. Co.*, 173 U.S. 1, and *Parker* v. *Russell*, 133 Mass. 74 (which undoubtedly hold that in such case entire damages are recoverable), overruled the demurrer. In this it was wrong. The obligation of the insurer is purely conditional with reference to each possible payment, and the conditions are ones of future fact which involve no correlative obligation of the insured. Assume the respondent is so disabled on July 11, 1933, as to require a $20 payment. On that day the petitioner is under a present obligation to pay him $20. If on August 11, 1933, also he is so disabled, another $20 obligation will then accrue, but not until that day. On July 12, 1933, or August 10 the petitioner owes him nothing, and is not then under a present obligation to pay him $20 on August 11th. Not until the conditions are all met does the obligation arise. Meanwhile the insured is under no contractual obligation from which he ought to be relieved by election to sue at once.

That this is the proper construction of the contract is shown by the discussion in the *Mobley* opinion, where this Court said:

> "The insurer's promise to pay monthly benefits was conditional on two events: the insured's disability as defined, and the specified proof. Its obligation was not an unqualified one to pay or to pay on the mere occurrence of disability but only after proof of that fact. Similarly its agreement to continue payments once begun was conditioned upon the persistence of insured's disability and, at the election of the insurer, proof of that fact by physical examination, but after two years not oftener than once a year. These conditions serve to define the insurer's promises but impose no obligation on the insured. By payment of the premium he acquired the options and privileges specified. He did not promise or in any manner bind himself to do or refrain from doing anything. The provision that the company may require proof of continuance of disability conditions the right of the insured to have future installments but imposes no obligation upon him. He was at liberty, without breach of contract, to refrain from making the claim or to refuse disclosure of his condition or to permit examination" (79 L. Ed. 939).

Assuming repudiation, therefore, there is no present breach of an obligation to pay future benefits, for there is no such present obligation. *Parker* v. *Russell, supra,* and similar cases cannot apply (133 Mass. at p. 76), and if damages are to be recovered, it must be upon the doctrine of anticipatory breach. But that doctrine requires mutual obligations; otherwise, as in the case of negotiable paper, it does not apply.

Roehm v. *Horst,* 178 U.S. 1, 17.

Here, as this Court pointed out in the *Mobley* case, there are no mutual obligations.

This difficulty was recognized by the majority in the *Rascoe* case and was evaded by construing the conditions into obligations resting upon the insured (12 F. (2d) 693, 696). The dissent (see p. 697) clearly shows that this was a misconstruction, and this Court has settled that matter by the statement just quoted.

If we are wrong, therefore, in our reading of the allegations showing breach, and they do establish a repudiation, this point of anticipatory breach is squarely raised upon the present record. Its importance was recognized by this Court when the question was expressly reserved at the end of the *Mobley* opinion. We hope the Court will now consider it.

3. The matter is one of great practical importance.

It is important to the petitioner and to all insurance companies to have the outstanding opinion of the Circuit Court of Appeals corrected.

If the opinion is to stand unreversed, all insurance companies with outstanding policies carrying disability benefits will be placed in a most unfortunate position.

This Court is of course aware of the great volume of litigation carried on by insurers relating to disability benefits. That type of insurance invites litigation perhaps more than any other type. There are very many policyholders who are suffering from some degree of physical disability. There is no room for question that many are able to pursue gainful employment. Others are as undoubtedly truly totally disabled. Between the extremes there is a great host of people as to whom it is impossible to say categorically that they are or are not able to work and earn money —given the opportunity. Each of them insists (honestly or

not) that he cannot do so. The most vexing situation arises in the cases of those policyholders who have been receiving benefits but whose disability is disappearing. People who are totally disabled (even when they hold insurance policies) do get better and become able again to carry on gainful occupation. When that happens the insurer has a right to stop the benefits. But if a jury finds otherwise upon the issue of degree of disability, the First Circuit would permit damages upon the theory that the insured will live many years and be totally disabled all the time.

Justice requires that the insurer should have the opportunity to litigate its contention quite as much as it requires that the truly disabled policyholder should receive his benefits. In each case the insurer's contention is precisely the same—the insured can now work and so the condition on which the benefit depends is not met. Consequently in each case the insurer says just that to the insured, who then brings suit if he disagrees. Prior to the *Rascoe* case (1926) that was a perfectly simple situation. If the insurer won, well and good; if it lost, the judgment merely required payment of the accrued indemnity and then payments were continued in the normal course until some further change occurred in the factual situation. Ordinarily only a few hundred dollars would be at stake.

But in 1926 Rascoe's lawyers succeeded in holding an insurer liable for $25,000, in just such a situation. If the law announced in that opinion was sound, the entire complexion of the situation had changed. The insurer was then faced with the necessity of meeting the claim, not only that the insured was still disabled at a possible cost of a few hundred dollars, but also that it had repudiated its policy, at a possible cost of many thousand. The result was that the litigation of disability claims became a most hazardous matter, and a perfectly honourable insurer might well hesi-

tate putting a perfectly honest and reasonable claim in litigation at such a stake.

It is against the policy of the law to subject litigants to such a hazard in settling bona-fide disputes. *Kimel* v. *Missouri State Life Insurance Co.*, 71 F. (2d) 921, 923 (C.C.A. 10).

In consequence, throughout the past nine years insurers have lost no opportunity to demonstrate that the *Rascoe* case is not good law. Until the present case they have met with consistent success at least in the Federal Courts. But now, unless this Court straightens the matter out, they are faced with a worse opinion than that in the *Rascoe* case—which at least was coupled with a well-reasoned dissent. In the report of that case the facts relating to the supposed "repudiation" are obscurely stated and the furthest that it goes is as authority for the proposition that, if there is repudiation, there can be recovery of entire damages. What constitutes repudiation is not discussed at length. But the opinion in the case at bar announces that a refusal to pay upon the asserted ground that "it appeared . . . that for some time past the plaintiff had not been continuously totally disabled" (R. p. 6), followed by a declaration that the policy has lapsed for non-payment of premium, is sufficient to constitute repudiation. That is an invitation to every disgruntled policyholder to claim entire damages in every case.

There is no occasion to doubt that the invitation will be accepted. Each case which formerly involved an insignificant amount will now involve enough to bring it within the jurisdiction of the Federal Courts. In a very great number of the cases there will also be the requisite diversity of citizenship. The consequence is that these cases will be brought in the Federal Courts. In view of the chilly reception accorded to the *Rascoe* case outside of the Sixth Circuit, there is no reason to suppose that the instant case will

be better received in the other circuits. Confusion will follow, with consequent injustice to the litigants which this Court will undoubtedly right sooner or later.

We do not believe this Court will approve the opinion of the Circuit Court of Appeals in this case. We are certain that it is to the great interest of the law that it settle the matter now once and for all.

Respectfully submitted,

LOUIS H. COOKE,
New York,

F. H. NASH,
C. R. BRANCH,
Boston.

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Supreme Court, U.S.
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CHARLES ELMORE CROPLEY

Supreme Court of the United States.

October Term, 1935.

No. 502.

New York Life Insurance Company,

Petitioner,

v.

Demetrios P. Viglas,

Respondent.

BRIEF FOR THE PETITIONER.

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Supreme Court of the United States.

October Term, 1935.

No. 602.

NEW YORK LIFE INSURANCE COMPANY,
Petitioner,
v.
DEMETRIOS P. VIGLAS,
Respondent.

BRIEF FOR THE PETITIONER.

Jurisdiction and Travel of the Case.

This action at law, commenced in the District Court for the District of Massachusetts, comes before this Court upon certiorari to the Circuit Court of Appeals for the First Circuit. Jurisdiction of the Federal Courts is asserted by the respondent on the basis of diversity of citizenship (U.S.C. Tit. 28, § 41 (1)).

The writ is dated November 9, 1933 (R. 1). It named $15,000 as the ad damnum. The petitioner demurred to the declaration on the ground that it showed a cause of action on which no more than $98 could be recovered, so that the District Court was without jurisdiction (R. 7, 8). The District Court sustained the demurrer. Its opinion (R. 9, 10) is not reported. The respondent appealed to the Circuit Court of Appeals. That Court reversed the judgment of the District Court. Its opinion (R. 11-17) is reported 78 F. (2d) 829. Judgment was entered by the Circuit Court of Appeals July 13, 1935 (R. 17). A petition

for rehearing filed by the petitioner was denied without opinion October 9, 1935 (R. 18). This Court granted the petition for certiorari December 23, 1935 (R. 29).

Statement of the Case.

The substitute declaration (R. 3-7) is based upon a life insurance policy issued by the petitioner to the respondent (R. 19-27). Under this policy the petitioner undertook to pay the beneficiaries (who are not parties to the litigation) $2000 upon the death of the respondent, and "upon receipt of due proof that the Insured is totally and presumably permanently disabled" (R. 19, 20) to pay to the respondent himself $20 for each completed month of total disability and to waive payment of premiums (otherwise payable semi-annually) by the respondent throughout the continuance of the disability. Careful provisions were in the policy covering this obligation (R. 20). The promise is to pay the monthly annuity "for each completed month from the commencement of and during the period of continuous total disability" and to waive premiums "falling due during the period of continuous total disability" (R. 20). Before making payments (subject to certain conditions not presently material) the petitioner might require proof of the continuance of the disability. If the insured should perform any work, no further payments should be made.

The substitute declaration contains two counts. Under the first, recovery of only $1408 is sought, so it may be disregarded. In the second it is alleged that on September 11, 1931, the respondent "became totally and permanently disabled within the terms and provisions of the contract," and that thereupon the petitioner honoured the claim made, paid the $20 monthly annuity to and including July 11, 1933, and waived premiums falling due prior to August 7, 1933. It is then alleged—

". . . that on or about September 1, 1933, the defendant refused to make the monthly payment due August 11, 1933, and refused to waive the semi-annual premium due August 7, 1933, asserting to the plaintiff as its ground for such refusal that since it appeared to the defendant that for some time past the plaintiff had not been continuously totally disabled within the meaning of the disability benefit provision of the policy, the defendant would make no further monthly disability payments, and that the premiums due on and after August 7, 1933, would be payable in conformity with the terms of the contract. Upon the expiration of the days of grace after August 7, 1933, for the payment of the semi-annual premium, the defendant on or about September 19, 1933, declared the policy as lapsed upon its records, the premiums not having been waived by the defendant nor paid by the plaintiff" (R. 6).

This is followed by an allegation that the respondent was in fact totally disabled throughout, and consequently that the refusal of the benefits was a breach by the petitioner and that the respondent "elected to treat said wrongful refusal of the defendant [petitioner] to perform its obligations under said contract as a repudiation and renunciation of the entire contract" (R. 6). Upon this basis entire damages were sought, based upon the respondent's life expectancy (thirty-six years) and his anticipation that he would remain disabled, amounting to some $15,900 (R. 7).

To this declaration the petitioner demurred (R. 7, 8) upon the ground that the allegations did not show a total breach and that the limit of the recovery on the allegations was the amount of accrued monthly payments and waiver of premium, amounting in all to $98, and so far below the jurisdictional requirement of more than $3000

(U.S.C. Tit. 28, § 41 (1)). As far as the demurrer is concerned, there has never been any dispute on the figures. The only question presented is whether the allegations show such a breach as to allow recovery of damages which would include future indemnity which might or might not accrue and become payable, depending upon future facts which cannot be prophesied with any exactness.

The District Court answered this question in the negative and sustained the demurrer (R. 9, 10). In support of the declaration the respondent relied heavily on the case of *Federal Life Insurance Company* v. *Rascoe,* 12 F. (2d) 693 (C.C.A. 6). The District Court treated that case as such authority, but refused to follow it, on the ground that it was contrary to the weight of authority.

On the respondent's appeal to the Circuit Court of Appeals he took the same position and based his argument upon the authority of the *Rascoe* case. The argument took place before *Mobley* v. *New York Life Insurance Company* was argued in this Court. The opinion was handed down after the decision of this Court in the *Mobley* case. In the opinion (written by Judge Morton) it was held that the allegations showed a total breach and repudiation of the policy which entitled the respondent to the entire damages which he sought. The *Rascoe* case was not mentioned, and an attempt was made to distinguish the *Mobley* case.

Specification of Errors.

The Circuit Court of Appeals erred—

(1) In refusing to follow the decision of this Court in *Mobley* v. *New York Life Insurance Company,* 295 U.S. 632.

(2) In holding that the declaration showed a repudiation of its contract by the petitioner upon allegations, without more, that (*a*) the respondent was entitled to continue to receive disability benefits from the petitioner, but that

(*b*) the petitioner refused to continue the benefits upon the ground (not alleged to have been taken *mala fide*) that the respondent had not met the conditions upon which only the benefits were payable, and (*c*) thereafter, upon failure to receive a premium, declared the policy lapsed.

(3) In ruling that, upon a total breach of a policy providing for monthly future payments conditioned upon the state of health of the policyholder at the beginning of each future month, the present value of those future payments, computed upon the assumption that the policyholders will live out the normal expectancy of an unimpaired life and continue to suffer total disability, may be recovered.

(4) In reversing the judgment of the District Court and ordering the petitioner's demurrer to the substitute declaration overruled.

Points and Authorities.

1. *The case is governed by the decision of this Court in the recent case of Mobley v. New York Life Insurance Company, 295 U.S. 632.*

The precise question presented upon the present record was before this Court in the case of *Mobley* v. *New York Life Insurance Company*. It will be observed that the insurer was the same in both cases. The policy provisions in the instant case cannot be described more succinctly than by following the language of the Court in that opinion. The policies held by both Mobley and Viglas provided—

> "That whenever the insured is so disabled by bodily injury or disease that he is wholly prevented from performing any work, following any occupation or engaging in any business for remuneration and the company receives proof that this disability will continue for life or that it has existed for the three months next preceding the proof, the company will pay monthly

ten dollars per thousand of face value and waive premiums; that, before making any income payment or waiving any premium, the company may demand proof of continuance of total disability (but not oftener than once a year after disability has continued for two full years) and that, upon failure to furnish such proof, no further payments will be made nor premiums waived" (295 U.S. 635).

Mobley became disabled under circumstances which entitled him to receive the monthly payments provided in the policy. Thereafter a dispute arose between him and the insurer as to whether his disability was still persisting, and—

> "March 1, 1933, the company wrote him stating it appeared that for some time he had not been continuously disabled within the meaning of the policies, that no further monthly payments would be made and that the premiums due on and after February 7 became payable according to the terms of the contracts" (295 U.S. 635, 636).

On April 13 the company notified Mobley that the policy had lapsed. Mobley immediately seized upon the company's action as constituting a total breach of the policy which would entitle him to recover at that time indemnity for a further period figured upon the theory that he would continue disabled and would live out his normal expectancy. The District Court for the Southern District of Mississippi, the Circuit Court of Appeals for the Fifth Circuit, and this Court all ruled that there could be no such recovery. This Court said in its opinion:

> "The evidence gives no support to the claim that it disregarded or intended to break its promises. We conclude that, as found by the lower courts—rightly

declining to follow the decision of the Circuit Court of Appeals for the Sixth Circuit in *Federal Life Ins. Co.* v. *Rascoe, supra,* [12 F. (2d)] 696—the company did not repudiate the policies. In view of that fact, we need not, and therefore do not, decide whether the doctrine of anticipatory breach is applicable to the class of cases to which this one belongs. *Dingley* v. *Oler, ubi supra,* [117 U.S. 490]'' (295 U.S. 639).

In the case at bar the respondent became disabled under circumstances which led the petitioner to make monthly payments to him under his policy. The petitioner received advices that his condition had improved and refused to make further payments. He brought suit, making the precise claim which Mobley had made. In his declaration he alleged—

''. . . that on or about September 1, 1933, the defendant refused to make the monthly payment due August 11, 1933, and refused to waive the semi-annual premium due August 7, 1933, asserting to the plaintiff as its ground for such refusal that since it appeared to the defendant that for some time past the plaintiff had not been continuously totally disabled within the meaning of the disability benefit provision of the policy, the defendant would make no further monthly disability payments, and that the premiums due on and after August 7, 1933, would be payable in conformity with the terms of the contract'' (R. 6).

Obviously no distinction can be drawn between these allegations of the respondent's declaration and the evidence tending to show breach summarized by this Court in the *Mobley* case.

The Circuit Court of Appeals referred to the opinion of this Court in the *Mobley* case, but did not make any attempt

to distinguish specifically between the allegations of the declaration which was before it and the facts on which this Court passed in the cited case. It contented itself with quotations from the opinion of this Court, laying down the broad general propositions of the law upon which such cases must depend and with the bare statement: "The facts alleged are essentially different from those in the *Mobley* case where it was held that the evidence did not show repudiation of the policy or a complete denial of liability on it by the company" (R. 15).

That statement is demonstrably not so. A comparison of the allegations of the breach in the respondent's declaration with the quotation from the opinion of this Court given above shows that there is no essential difference and indeed that both employ almost identical words. This is not extraordinary in view of the fact that both obviously were taken from the same form letter sent in such cases by New York Life Insurance Company to policyholders making claims like those of Mobley and the respondent.

The Circuit Court of Appeals made a point of the further allegation contained in the declaration that the petitioner had declared the policy lapsed upon its records. The allegation of the declaration on this point was as follows:

> "Upon the expiration of the days of grace after August 7, 1933, for the payment of the semi-annual premium, the defendant, on or about September 19, 1933, declared the policy as lapsed upon its records, the premiums not having been waived by the defendant nor paid by the plaintiff" (R. 6).

Referring to this allegation the Circuit Court of Appeals said:

> "As we construe the declaration it alleges a complete and unqualified denial by the defendant of all liability on the policy. It states that the defendant not

> only refused to pay benefits due but wrongfully lapsed the policy for non-payment of premiums. An unconditional lapsing of the policy was a complete termination of it and a denial by the defendant of any further liability on it. There is no allegation that the defendant recognizes any further rights of the plaintiff in the policy, or any further liability upon it. . . . On the allegations of the declaration we are of opinion that the plaintiff was entitled to maintain the action and, if the lapsing was found to be a complete and unqualified denial by the defendant of any further liability on the policy and was unjustified that the plaintiff would be entitled to recover damages equivalent to the value to him of the contract which was broken" (R. 15).

But this allegation in no way distinguishes the instant case from the *Mobley* case. There also the insurer declared the policy lapsed. In both cases the company was simply referring to the express provision contained in the policies that the policy should not remain in force beyond the date when the next premium payment should become due (R. 24). It is only by a clear misconstruction of the allegations of the declaration that it is possible to say that they show "a complete and unqualified denial . . . of all liability on the policy." The notification of September 1, 1933, specifically stated that it was sent upon the ground, not that there was anything wrong with the policy, but that the respondent was not then continuously totally disabled, and it was coupled with a statement that the premiums due thereafter would be payable "in conformity with the terms of the contract"—thus specifically recognizing that the policy was then still in force.

The further notification that the policy had lapsed, sent after the time for the payment of the premium had passed,

added nothing to the situation. If the premium was in fact payable, it was a simple notification that the policy had expired by its own terms. If, on the other hand, the premium should have been waived, it was entirely nugatory, added nothing to what had already gone before, and cannot be taken to indicate any intention on the part of the petitioner not to recognize its policy obligations.

The fact that it appeared in evidence in the *Mobley* case that after the insurer had refused to continue benefits and had notified Mobley of the lapse of its policy it reversed its decision and tendered benefits to Mobley, which were refused, forms the basis for no distinction between the two cases. Mobley brought his action on the basis that there had then accrued to him a complete cause of action to recover the entire amount sought, and that nothing done thereafter by the defendant could change the situation. It was on this basis that the case was decided. The behaviour of the insurer after the action was commenced was pertinent on the question of whether the original refusal to continue the benefits was made in good faith or not. In the present case this issue is not presented, since there are no allegations in the declaration that the petitioner did not act in good faith and the asserted ground of its action was one which was clearly open to it entirely irrespective of whether it may have been wrong in its understanding of the factual situation.

There are no allegations in the declaration that the petitioner took its position in anything other than entire good faith or that it intended to break its promises. The declaration shows a breach of the obligation to make current payments, but it does not purport to allege that the petitioner repudiated the contract. The *Mobley* case is controlling authority to the effect that no such breach as is alleged will warrant assessment of the damages sought.

2. The doctrine of anticipatory breach, which alone could sustain the respondent's position, does not apply to the case.

If, contrary to our submission, there are grounds upon which this case can be distinguished from the *Mobley* case, the action of the District Court in sustaining the demurrer was nevertheless correct.

The obligation which the petitioner undertook under the policy was a strictly conditional one. It was that *if* the respondent became totally and presumably permanently disabled, the petitioner would each month thereafter pay the respondent $20 *if* he was still disabled with the passage of each month. Until these conditions are met there is no present obligation on the insurer. Assume that on July 11, 1933, the respondent is so disabled as to entitle him to payments and has made proper proof of his condition. On that day (assuming it to be the last day of a "completed month" (R. 20) of disability) an obligation on the petitioner to pay $20 accrued. It was discharged by payment. On the next day, July 12, and until August 11 the petitioner was under no present obligation with reference to further payments. If the respondent continued disabled throughout the ensuing month, a new obligation to pay $20 would arise on August 11 on the completion of the month, but it would not arise until that day. And in the same way on August 12 there would be no present obligation with respect to a payment to be made on September 11.

The situation thus presented is to be distinguished from that found in cases like *Parker* v. *Russell,* 133 Mass. 74 (a contract to support for life), which the Circuit Court of Appeals considered controlling (see R. 16). That sort of case presents a situation where there is a present accrued obligation to make periodic payments in the future. There, if the party refuses to make a payment, there is a present breach of the single obligation and damages are immediately recoverable (see *Parker* v. *Russell,* 133 Mass. 74; *Pakas* v.

Hollingshead, 184 N.Y. 211; *Pierce* v. *Tennessee Coal &c. Co.,* 173 U.S. 1). But they are recoverable for reasons wholly unconnected with the doctrine of anticipatory breach. The obligation has accrued although the time for full performance has not yet arrived. No condition exists to interfere with the accrual of the obligation. But in the present case on August 12 the only accrued obligation is to pay the $20 due August 11. Although a further obligation to pay $20 on September 11 may accrue when that day arrives, it has not accrued on August 12 and cannot accrue until that day arrives, for only then can the condition be met. In effect the disability provisions of the policy constitute a series of contracts, one relating to each month and each subject to its own condition precedent. It therefore follows that on August 12 there can be no present breach of any obligation to make future payments. If there is any breach at all, it must be an anticipatory breach.

The only case before this one in which a Federal Court has allowed recovery of future installments of a disability annuity such as this placed its decision on the ground of anticipatory breach.

> *Federal Life Insurance Co.* v. *Rascoe,* 12 F. (2d) 693 (C.C.A. 6).

Later Federal cases discussing the point put it upon that same footing.

> *Kimel* v. *Missouri State Life Insurance Co.,* 71 F. (2d) 921 (C.C.A. 10).
>
> *Menssen* v. *Travelers Ins. Co.,* 5 Fed. Supp. 114 (E.D. N.Y.).
>
> *Kithcart* v. *Metropolitan Life Insurance Co.,* 1 Fed. Supp. 719 (W.D. Mo. W.D.).
>
> *Wyll* v. *Pacific Mutual Life Insurance Co.,* 3 Fed. Supp. 483 (N.D. Tex.).

Hines v. *Fidelity Mutual Life*, 6 Fed. Supp. 692 (E.D. N.Y.).

Smith v. *Mutual Benefit &c. Assn.*, 10 Fed. Supp. 110 (D.C. W.D. Okla.).

(In none of these cases was recovery allowed.)

The respondent argued the case in both the District Court and the Circuit Court of Appeals as a case of anticipatory breach. It was to provide a basis for that argument that the allegation that the respondent "elected to treat said wrongful refusal of the defendant to perform is obligations under said contract as a repudiation and renunciation of the entire contract" (R. 6) was inserted in the declaration.

It is well established that a party who asserts an anticipatory breach of a contract must show a clear, unequivocal repudiation of it by the other party. Nothing short of that will suffice.

Dingley v. *Oler*, 117 U.S. 490.

In that case the Court considered correspondence in which the defendant had refused to comply with the plaintiff's request, and said (at p. 502):

> "This, we think, is very far from being a positive, unconditional, and unequivocal declaration of a fixed purpose not to perform the contract in any event or at any time. In view of the consequences sought to be deduced and claimed as a matter of law to follow, the defendants have a right to claim that their expressions, sought to be converted into a renunciation of the contract, shall not be enlarged by construction beyond their strict meaning."

Nothing short of definite repudiation will suffice.

Johnstone v. *Milling*, 16 Q.B.D. 460.

This requirement was again affirmed in the *Mobley* case, where the Court said (295 U.S. 638):

> "Repudiation by one party, to be sufficient in any case to entitle the other to treat the contract as absolutely and finally broken and to recover damages as upon total breach, must at least amount to an unqualified refusal or declaration of inability, substantially to perform according to the terms of his obligation. *Roehm* v. *Horst,* 178 U.S. 1, 14, 15. *Smoot's Case,* 15 Wall. 36, 49. *Dingley* v. *Oler,* 117 U.S. 490, 503. *Kimel* v. *Missouri State Life Ins. Co.,* 71 F. (2d) 921, 923. Mere refusal, upon mistake or misunderstanding as to matters of fact or upon an erroneous construction of the disability clause, to pay a monthly benefit when due is sufficient to constitute a breach of that provision, but it does not amount to a renunciation or repudiation of the policy. *Daley* v. *People's Building, L. & S. Assn.,* 178 Mass. 13, 18; 59 N. E. 452."

The respondent by his allegations did not bring himself within this requirement. It has already been shown that the allegations of this declaration do not go beyond the proof considered in the *Mobley* case, which was held insufficient to constitute a repudiation. Here there is no allegation of any repudiation of the policy. It is simply alleged that "the defendant refused to make the monthly payment due August 11, 1933" (R. 6). And coupled with this is the further allegation that the refusal was because the respondent was not "totally disabled *within the meaning of the disability benefit provision of the policy*" (R. 6), and consequently no further payments would be made. But this shows beyond question that the refusal was based upon the letter of the contract. It was also alleged that with this refusal the petitioner notified the respondent that the premiums thereafter "would be payable *in conformity*

with the terms of the contract." This expressly recognized the continued existence of the policy as a binding contract. The petitioner was claiming the right reserved to it in the policy not to make payments unless the respondent was disabled. Such a claim in the nature of things could not constitute a repudiation of the contract. But nothing short of repudiation could justify recovery of more than overdue payments.

The further allegation that at the expiration of the grace the petitioner "declared the policy as lapsed upon its records, the premiums not having been waived . . . nor paid" (R. 6), adds nothing. Lapse is something which happens in accordance with the terms of a policy and is to be distinguished from repudiation. Lapse signifies termination of the policy in accordance with its provisions, not a repudiation which would terminate the contract contrary to its provisions.

The first requirement for a cause of action for anticipatory breach (that there be an unqualified repudiation of the contract by the defendant) is, therefore, lacking. But that is not the only lack apparent on this declaration. To show such a cause of action it is also essential that the contract contain mutual executory obligations. Where no obligation rests upon the plaintiff, as in the case of a holder of negotiable paper, the doctrine does not apply.

> *Roehm* v. *Horst,* 178 U.S. 1, 17.
> *Central Trust Co.* v. *Chicago Auditorium,* 240 U.S. 581, 589.
> *Moore* v. *Security Trust &c. Co.,* 168 Fed. 496 (C.C.A. 8).

The holder of an insurance policy containing disability benefit provisions has no obligation resting upon him. He is required to do nothing. This was recognized by

Judge Denison in his dissent in the *Rascoe* case (12 F. (2d) 697). The majority in that case sought to bring the case within the rule by construing the *condition* that to recover the policyholder must furnish proof of his disability as an *obligation* to do so (12 F. (2d) 696). Obviously that is an improper construction. This Court considered the point in the *Mobley* case. It said (295 U.S. at 637, 638):

> "The insurer's promise to pay monthly benefits was conditioned on two events: the insured's disability as defined, and the specified proof. Its obligation was not an unqualified one to pay or to pay on the mere occurrence of disability but only after proof of that fact. Similarly its agreement to continue payments once begun was conditioned upon the persistence of insured's disability and, at the election of the insurer, proof of that fact by physical examination, but after two years not oftener than once a year. These conditions serve to define the insurer's promises but impose no obligation on the insured. By payment of the premium he acquired the options and privileges specified. He did not promise or in any manner bind himself to do or refrain from doing anything. The provision that the company may require proof of continuance of disability conditions the right of the insured to have future installments but imposes no obligation upon him. He was at liberty, without breach of contract, to refrain from making the claim or to refuse disclosure of his condition or to permit examination."

The entire absence of obligation on the part of the policyholder makes the doctrine of anticipatory breach entirely inapplicable.

See *Killian* v. *Metropolitan Life Ins. Co.*, 251 N.Y. 44, 48.

Since the declaration does not show a repudiation by the petitioner of a mutually executory contract, there can be no recovery on the theory of anticipatory breach. It does show a cause of action for present breach—but one on which only $98 can be recovered. The breach shown consists only of failure to pay accrued benefits. It cannot affect further obligations which, though they may or may not arise in the future, have not yet accrued. In this the Circuit Court of Appeals fell into error. That Court wholly failed to appreciate the nature of the obligation of the petitioner under this contract. It considered the case as one within the rule of *Parker* v. *Russell,* 133 Mass. 74, and *Pierce* v. *Tennessee Coal &c. Co.,* 173 U.S. 1, both *supra* (see R. 15). It did not recognize that there was no accrued obligation on the petitioner with reference to future months. Its judgment overruling the demurrer was, consequently, erroneous.

3. Aside from the rules of law heretofore discussed, it would be unjust to permit the recovery sought by the respondent.

Prior to the decision in the *Rascoe* case, 12 F. (2d) 693 (C.C.A. 6), no Federal Court had permitted recovery of damages based upon future disability payments which might or might not accrue, depending upon whether the insured continued to live and suffer. The opinion of the Circuit Court of Appeals in the present case is the first since the *Rascoe* case which permits such recovery.* This

*The following are all of the cases in which the *Rascoe* case has been cited: In *Schmitt* v. *Mass. Protective Assn.,* 32 F. (2d) 61 63 (C.C.A. 8), it was referred to as cited by the defendant; it was not applied or followed. In *Parks* v. *Maryland Cas. Co.,* 59 F. (2d) 736, 737 (D.C. W.D. Mo., W.D.), it was distinguished and the dissent commended. The Court held there could be no recovery of future disability benefits. In *Kithcart* v. *Metropolitan Life Ins. Co.,* 1 Fed. Supp. 719 (D.C. W.D. Mo., W.D.), it was distinguished and the *Parks* case was followed. In *Wyll* v.

Court in the *Mobley* case at the conclusion of its opinion said (295 U.S. 639):

> "We conclude that, as found by the lower courts—rightly declining to follow the decision of the Circuit Court of Appeals for the Sixth Circuit in *Federal Life Ins. Co.* v. *Rascoe, supra,* 696—the company did not repudiate the policies. In view of that fact, we need not, and therefore do not, decide whether the doctrine of anticipatory breach is applicable to the class of cases to which this one belongs. *Dingley* v. *Oler, ubi supra.*"

Reasons, which seem compelling to the petitioner, have already been given why the doctrine of anticipatory breach cannot apply to cases like the present. In addition there are practical reasons against its application which merit the consideration of the Court.

At the outset it is to be observed that the insurer never agreed in the policy to pay a lump sum. What it agreed

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Pacific Mutual Life Ins. Co., 3 Fed. Supp. 483, 484 (D.C. N.D. Tex., Dallas Div.), it was again distinguished and the dissent commended. In *Menssen* v. *Travelers Ins. Co.*, 5 Fed. Supp. 114, 115, 116 (D.C. E.D. N.Y.), its reasoning was questioned and the *Wyll*, *Kithcart*, and *Parks* cases were followed. The same was true in *Ginsburg* v. *Pacific Mutual Life Ins. Co.*, 5 Fed. Supp. 296 (D.C. S.D. N.Y.). In *Mobley* v. *New York Life Ins. Co.*, 74 F. (2d) 588, 590 (C.C.A. 5), it was not followed, and numerous of the state cases disapproving it were referred to. In *Davies* v. *Sun Life Assur. Co.*, 2 Fed. Supp. 955, 957 (D.C. W.D. Wash., N.D.), it was referred to without comment as cited by the plaintiff. A motion to remand was denied on the ground that there was enough diversity in the cases on the point to raise some question. This case was disapproved in the *Menssen* case, *supra.* In *Prudential Ins. Co.* v. *Faulkner,* 68 F. (2d) 676, 680 (C.C.A. 10), a case dealing with the payment of the face of the policy as a disability benefit, it was discussed at some length and without enthusiasm. It is difficult to discover any opinion of a Circuit Court of Appeals which has received such a chilly reception by the Courts.

to do and what the insured bargained for was that it should make payments monthly. The object of those payments, of course, was to provide a current income to the insured while disabled from earning. If the insured, instead of receiving that monthly income, receives one lump sum, the entire scheme of the contract is defeated and he receives something very different from what he bargained for. In the absence of controlling reasons this should not be permitted.

Whatever might be the situation where the insurer went out of business (cf. *Lovell* v. *St. Louis Mutual Ins. Co.*, 111 U.S. 264) and so made it impossible for the insured to receive his bargain, or where the insurer in bad faith harassed the insured by repeated and vexatious refusals to pay, in a case like the present there are no such compelling reasons for permitting such speculative damages. There has been one refusal to pay upon the ground that nothing was due (see *Kimel* v. *Missouri State Life Ins. Co.*, 71 F. (2d) 921, 923, *supra; Daley* v. *People's Building &c. Assn.*, 178 Mass. 13). There are no allegations suggesting that, if it shall be determined that the respondent is really disabled, the petitioner will not accept that determination. If on the 11th days of August, September, and October, 1933, the respondent was totally disabled, he should receive $20 for each of those months. And the same applies to each month since then. But there is no sound reason why he should instead now receive $15,900.

The fundamental reason generally advanced as the ground for the doctrine of anticipatory breach is the practical convenience which it affords.

See 3 Williston, Contracts, § 1321.

Here there is no practical convenience. Instead of assisting the plaintiff speedily to obtain what he should receive,

he is given something he never bargained for in its place. The rule should never be pushed beyond its reason.

Justice, therefore, does not require that a plaintiff have this novel remedy. But further, to give it to him is to do injustice to the defendant. The entire damages which the plaintiff would receive must be based very largely indeed upon conjecture. Those which the respondent sought here are based upon his life expectancy. He assumes (R. 7) that he will live 432 months (36 years) *and* that he will continue to be totally disabled throughout each one of those 432 months. There is no way in which that can be proved. Life expectancy tables, as the Court knows judicially, apply only to normal lives. On his own showing the respondent's is an impaired life. The only known method of making a prophecy, acceptable to the law, that the respondent will live thirty-six years, or ten years, or one year cannot therefore apply in this sort of case. And that is only half of the case. To recover these damages the respondent must not only show he will live, he must also show that he will continue *totally* disabled. On this there is no possible ground on which to found a prophecy. Physicians can speculate, but that does not satisfy the law. The matter was put somewhat quaintly by the attorney general *arguendo* in *Chesterfield* v. *Janssen,* 1 Atk. 301, 329, when he said:

> "Physicians are not certain, nor infallible; they pronounce people dead and yet they recover and bite them."

If an insurer is now required to pay a large sum upon the chance (which cannot be determined by any legal proof) that an insured will continue disabled, it obviously is highly probable that it will be required to pay more than if it is held to the letter of its contract and required to keep up

the monthly annuity. Damages for breach of contract are supposed to compensate the plaintiff, not penalize the defendant. For example, where suit is brought upon an alternative contract, damages are given upon the least onerous alternative.

Restatement, Contracts, § 344:

> "The damages for breach of an alternative contract are determined . . . in case of breach without an election, in accordance with the alternative which will result in the smallest recovery."

In the absence of controlling reasons the insurer should not be subjected to any such hazard.

One result of this hazard, if such actions are to be allowed, is that it places the insurer in an extremely dangerous position in all disability cases. The Court is, of course, aware of the great volume of litigation arising out of disability insurance. There are hosts of policyholders who are suffering from some measure of disability. In each case it may well be a matter of opinion as to the degree of disability. If the policyholder claims benefits which the insurer denies are due him, every consideration of justice requires that the Courts be open to the insurer to litigate the dispute.

Kimel v. *Missouri State Life Ins. Co.*, 71 F. (2d) 921 (C.C.A. 10), *supra.*
Daley v. *People's Building &c. Assn.*, 178 Mass. 13.

The insurer has no desire to repudiate its contract; it simply wishes to limit its payments to its obligations. But if a denial of the disability, if wrong in fact, constitutes a breach of the contract which will enable the insured immediately to recover total damages, it will require considerable hardihood on the part of the insurer to exercise its

undoubted right to litigate the question. It is one thing to litigate a case involving at most a few hundred dollars. It is quite a different thing where many thousands are at stake.

Moreover, there are many cases in which an insurer within the contestable period receives a claim for disability which upon investigation shows ground for believing that the entire policy was so obtained as to be voidable. Public policy requires that the insurer have the opportunity to litigate that question and avoid the policy if its contention is well founded.

> *Reagan* v. *Union Mutual Life Ins. Co.*, 189 Mass. 555.
>
> *New York Life Ins. Co.* v. *Hardison*, 199 Mass. 190.

But will it dare try if the result is to subject it to present liability for a large sum if the contention proves not well founded? This is a greater hardship yet. In the first case, where there is a simple denial of disability, there is no repudiation of the contract. That is settled by the *Mobley* case. But in this second case there is a clear repudiation. The result of allowing recovery of entire damages in that situation is to make unduly hazardous the resort to the Courts which public policy requires shall be open to the insurer.

> See *Cobb* v. *Pacific Mutual Life Ins. Co.*, 51 Pac. (2d) 84, 88 (Calif. Supreme Court, Oct. 31, 1935).

Here again there is no hardship on the insured in denying recovery of something he never bargained for. If the question of whether the policy can be avoided is decided in his favour, he has the policy he thought he had and will receive the benefits he purchased. He will have lost nothing.

He certainly should be made whole, but as certainly the insurer should not be penalized for making the *bona fide* contest from which public policy says he shall not disable himself.

We urge these practical considerations on the Court. Save for the *Rascoe* case (12 F. (2d) 693), there is no authority in the Federal books permitting present recovery for future disability benefits where the insurer continues in business and acts in good faith. The *Rascoe* case has been cited only to be distinguished. It is poorly reasoned and reaches its result by a distorted construction of policy provisions. There is a strong dissenting opinion from an eminent judge. We submit that it is no authority and that the matter is now to be considered as *res integra*. In that situation practical considerations of hardship on the defendant and lack of benefit to the plaintiff are entitled to great weight. The Court should, we submit, hesitate to extend the doctrine of anticipatory breach, which is based upon practical convenience, to a class of contract to which it has not been applied before and to a sort of case in which it affords no practical convenience, but, on the contrary, results in great practical hardship.

Respectfully submitted,

LOUIS H. COOKE,
F. H. NASH,
RICHARD WAIT.

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CHARLES ELMORE

Supreme Court of the United States.

October Term, 1935.

No. 602.

New York Life Insurance Company,

Petitioner,

v.

Demetrios P. Viglas,

Respondent.

REPLY BRIEF FOR PETITIONER.

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REPLY BRIEF FOR PETITIONER.

1. The Jurisdictional Point was Properly Presented by the Demurrer.

On page 2 of the respondent's brief it is argued that, since he sought large damages in good faith, the demurrer could not properly have been sustained. This argument is based upon the theory that, where more than $3000 is claimed in good faith, the fact that less may be ultimately recovered is immaterial as far as the jurisdiction is concerned. In support of this proposition the respondent cites *Kimel* v. *Missouri State Life Insurance Co.*, 71 Fed. (2d) 921 (C.C.A. 10th), and *The Fair* v. *Kohler Die & Specialty Co.*, 228 U.S. 22. Neither of these cases has any application to the present case. In the *Kimel* case three causes of action were declared on. The first was for $50 per month as disability benefits from September, 1925, to January, 1932,

amounting in all to $3750; the second was for the present value of $50 a month during the plaintiff's life expectancy; and the third was for premiums paid amounting to some $1500. The defendant had moved that the case should be dismissed for want of jurisdiction. This motion was patently unfounded in view of the perfectly reasonable claim for $3750 and consequently was properly denied. The case could apply to the present situation only if the sole cause of action declared on had been the second for recovery of the expectancy. That was not the case before the court and was not the point considered by the court.

In the case of *The Fair* v. *Kohler Die & Specialty Co.* jurisdiction was asserted under the patent laws. The plaintiff was a resident of the same state as the defendant and could have had no other ground (p. 24). The case does no more than hold that there is jurisdiction though the defendant denies the merits.

It is well established that, where the plaintiff's own pleading discloses that less than the jurisdictional amount is recoverable, the case is not within the jurisdiction of the Federal courts.

> *Vance* v. *W. A. Vandercook Company*, 170 U.S. 468, 472:
>
> "In determining from the face of a pleading whether the amount really in dispute is sufficient to confer jurisdiction upon a court of the United States, it is settled that if from the nature of the case as stated in the pleadings there could not legally be a judgment for an amount necessary to the jurisdiction, jurisdiction cannot attach even though the damages be laid in the declaration at a larger sum."

That is the precise situation presented here. The petitioner contends that it appears from the face of the declaration

that less than $3000 is legally recoverable. In view of that situation the Court had no jurisdiction. The case on this point is the same as if the plaintiff declared upon a bond in the penal sum of $1000, attached a copy of the bond to his declaration, and claimed damages in the sum of $4000. No such claim could give jurisdiction.

Wilson v. *Daniel,* 3 Dall. 401, 407, Ellsworth, C. J.:

> "The nature of the case must certainly guide the judgment of the court; and whenever the law makes a rule, that rule must be pursued. Thus, in an action of debt on a bond for £100, the principal and interest are put in demand and the plaintiff can recover no more, though he may lay his damages at £10,000. The form of the action, therefore, gives in that case the legal rule. But in an action of trespass, or assault and battery, where the law prescribes no limitation as to the amount to be recovered and the plaintiff has a right to estimate his damages at any sum, the damage stated in the declaration is the thing put in demand, and presents the only criterion to which, from the nature of the action, we can resort in settling the question of jurisdiction. The proposition, then, is simply this: Where the law gives no rule, the demand of the plaintiff must furnish one; but where the law gives the rule, the legal cause of action, and not the plaintiff's demand, must be regarded."

This is quoted with approval in—

Barry v. *Edmunds,* 116 U.S. 550, 560.

Suppose the plaintiff declared on one note for $1000 past due and another note for $3000 due in the future. Would the Federal court have jurisdiction?

2. The Nature of the Alleged Disability does Not Change the Situation.

The respondent refers in his brief to the fact that the disability alleged was the irrecoverable loss of the use of a hand and foot (see respondent's brief, pp. 3, 5, 9). By this he apparently intends to argue that the allegation—

> "The plaintiff says he lost the total and irrecoverable use of one hand and one foot" (R. p. 5)—

fixes the liability of the petitioner to pay disability benefits for his entire life, and so avoids the position taken by the petitioner that disability benefits only accrue with the passage of each completed month of disability. The argument is based upon the provision in the policy that—

> "The total and irrecoverable loss . . . of the use of . . . one hand and one foot shall constitute total disability for life" (R. p. 20).

But the continuance of this disability rests upon prophecy quite as fully as any other disability. The allegation that the loss is "irrecoverable" is one of prophecy. The company's assertion that for some time past the respondent had not been continuously totally disabled was an assertion that he had recovered at least partial use of hand or foot. It is quite as possible to recover from such a disability as from any other, and the insurer must have an equal right to contest the point without being charged with repudiation of the policy. The situation presented is not that which would arise if the allegation had been that one hand and one foot had been severed. The allegation refers only to the use.

3. The Claim of Hardship on the Respondent.

The respondent repeatedly refers to the great hardship which might be forced upon an insured by requiring him to

litigate repeatedly the question whether he is in fact totally disabled. He bases this argument very largely upon the proposition that the lapse of the policy declared by the petitioner was "unconditional." No situation raising any such hardship as he suggests is presented upon this record. That situation necessarily proceeds upon an assumption that an insurer is acting in bad faith. There are no allegations in the declaration suggesting any such position by this petitioner. Obviously a policyholder is not to be required to bring suit each month over a period of years, but quite as obviously nothing is shown here suggesting that the petitioner seeks to force him to do so.

The statement that the lapse was "unconditional" is not included in the declaration. That was something thrown in by the Circuit Court of Appeals in its opinion. The allegation is simply that the respondent—

> "declared the policy as lapsed upon its records, the premiums not having been waived by the defendant nor paid by the plaintiff" (R. p. 6).

Clearly this was a declaration under the terms of the policy. The policy specifically provides that the insured within six months after default in payment of the premiums may be reinstated by furnishing proof of continuous disability for at least three months since the default:

> "In event of default in payment of premium after the Insured has become totally disabled as above defined, the policy will be restored and the benefits shall be the same as if said default had not occurred, provided due proof that the Insured is and has been continuously from date of default so totally disabled and that such disability will continue for life or has continued for a period of not less than three consecutive months, is received by the Company not later than six months after said default" (R. p. 20).

Furthermore, the policy provides that the effect of lapse, if the policy is not restored under the above clause without payment of premium, or reinstated with payment of premium upon evidence of insurability (R. p. 21), is simply that the policy is not maintained in force beyond the date when the payment became due, "except as to the benefits provided for herein after default in premium payment" (R. p. 24). These benefits are the surrender values stated for the election of the insured. If he makes no election, the policy is continued automatically as temporary insurance from the date of default for such term as the value will purchase (R. p. 23).

The Circuit Court of Appeals was wrong in construing a simple allegation that the company "declared the policy as lapsed upon its records" as meaning "a complete termination of it and a denial by the defendant of any further liability on it" (R. p. 15).

Upon receiving the notice of the lapse, paying the premium under protest was not the only course open to the respondent. He could file proof of disability under the clause just quoted; he could bring a bill in equity to restrain the company from lapsing the policy; he could sue under the state declaratory judgment statute for a declaration that he was totally disabled; and, further, a judgment in an action to recover disability benefits accrued on August 11 would be *res judicata* that the policy did not lapse on August 7.

On the allegations of the present declaration there is nothing to show that more than one proceeding in court would be required to establish the respondent's rights. The hardship referred to in his brief is entirely imaginary. The law would be able to give relief if compensation were wilfully and contumaciously withheld.

Cobb v. *Pacific Mutual Life Insurance Co.*, 51 Pac. (2d) 84 (Calif. S.C.).

4. The Respondent's Authorities.

On page 6 of the respondent's brief four state court cases are cited as showing that there may be anticipatory breach. The citation of *Robbins* v. *Travelers Ins. Co.*, 269 N.Y.S. 841, is of the decision of the special term. The case was appealed to the Appellate Division, which dealt with it solely on the ground that the pleadings showed a cause of action only for the accrued benefits—241 App. Div. 350. The opinion of the special term is not authority. The case of *Milburn* v. *Royal Union Mutual Life Ins. Co.*, 234 S.W. 378, was expressly overruled by the Missouri Court of Appeals, which decided it in the later case of *Allen* v. *National Life & Accident Co.*, 67 S.W. (2d) 534, 535. The case of *Indiana Life Endowment Co.* v. *Reed*, 103 N.E. 77, contains much discussion of the point and decides that the evidence showed no repudiation of the policy. The case of *Equitable Assurance Society* v. *Pool*, 71 S.W. (2d) 455 (Ark.), is the only case cited which sustains the respondent's point. It is submitted that that case is wrong. The Federal case of *Minnesota Life* v. *Marshall*, 29 Fed. (2d) 977 (C.C.A. 8th), wrongly cited as "79 F. (N.D.) 977," is concerned with an entirely different point.

The final draft of the American Law Institute's Restatement of the Law of Contracts is clearly contrary to the respondent's contention. Sec. 318 (*e*):

> "The doctrine of anticipatory breach is not extended to unilateral contracts unless the promisor's duty is conditional on some future performance by the promisee. . . . There must be some dependency of performances in order to make anticipatory breach possible."
>
> "Illustration 9. A in consideration of $500 then paid to him by B promises B that on the further payment by B on the first day of the following May of $10,000

A will transfer Blackacre to B. Before that day A sells Blackacre to C. A has committed an anticipatory breach of contract.

(The reason is that B ought to be freed from the necessity of keeping his $10,000 ready)

"Illustration 10. A in consideration of $10,000 then paid to him by B promises B to transfer Blackacre to B on the first day of the following May. Before that day A tells B that he will not transfer the land as promised. Since the contract is unilateral, A has not committed an anticipatory breach of contract."

The respondent treats *Pierce* v. *Tennessee &c. R.R. Co.*, 173 U.S. 1, and *Parker* v. *Russell*, 133 Mass. 74, as authorities for holding that upon a contract to pay during life, subject to the promisee's condition from time to time in the future, an action may be maintained to recover future damages contingent upon a future breach. The Circuit Court of Appeals likewise misapplied these cases. In them there was nothing contingent about the obligation. The only contingency was as to the length of time through which the plaintiff would live (see petitioner's brief, pp. 11, 12). It is to be noted that the headnote in the *Pierce* case is not exact. The written contract sued on, which superseded the previous oral promises, was a promise to pay for life, not during disability. There is a clear distinction between an absolute contract to pay for life or to pay an annuity and a contract to pay $20 in August, 1966, provided the promisee has been continuously disabled until that time. In the present case the obligation for each future month is contingent upon the future disability. In the *Pierce* and *Parker* cases the only contingency was the amount of damage, that is, the length of the life.

The situation is much the same as in a case where the contract is to make payments to the promisee "while he

is sober and well behaved." In that situation a breach justifies recovery only to the date of the writ. The existence of the condition of sobriety prevents the recovery of future damages.

Fay v. *Guynon,* 131 Mass. 31.

So also with the alimony cases. The condition that payments are due only while the plaintiff remains unmarried prevents present recovery for future instalments.

Dunbar v. *Dunbar,* 190 U.S. 340, 346.
Linton v. *Linton,* 15 Q.B.D. 239.

The respondent appears to take comfort from the fact that this Court denied certiorari in the *Rascoe* case (273 U.S. 722). There can be no justification for this position. This Court has many times stated that denial of a petition for certiorari does not mean approval of the opinion of the lower court. Moreover, in this particular instance it seems clear that no other course was open to this Court but to deny the petition. The *Rascoe* case was tried without a jury, and the judge did not make separate findings. This was pointed out in the opinion. The court stated that—

> "Without such separate findings of facts, neither the evidence nor the question of law presented by it is reviewable by this court" (12 Fed. (2d) 695).

This was likewise noticed in the reference to the case in *Kithcart* v. *Metropolitan Life Insurance Co.,* 1 Fed. Supp. 719, and in *Wyll* v. *Pacific Mutual Life Insurance Co.,* 3 Fed. Supp. 483, 484. The point presented upon this record was not properly presented in the *Rascoe* case, and there was no occasion for this Court to decide a point not open on the record simply because the majority of the Circuit Court of Appeals for the Sixth Circuit had seen fit to do so.

The notion that a life insurance policy may be subject to the doctrine of *Roehm* v. *Horst,* 178 U.S. 1, is a grave menace when, as in the *Rascoe* case, the policy contains a total and permanent disability clause. The company is under a duty to repudiate a policy when, for example, the policy is obtained by substituting for a moribund applicant a healthy person to be examined, or by fraud in the application, or when the policy was not accepted and paid for during the applicant's lifetime. These are common examples of utter renunciation. If the jury believe the applicant, a verdict and judgment for outrageous "damages" may follow.

On the other hand, if a life insurance contract alone is repudiated, it makes no important difference to the company whether the insured prevails on the theory of present damages or merely establishes the validity of the policy, because the damages would be the present worth of the face of the policy less the present worth of the premiums payable during the insured's expectancy. The plaintiff would rather have specific performance than damages. Hence the question rarely arises.

It arose and was wrongly decided in—

Aetna Life Insurance Co. v. *Geher,* 50 Fed. (2d) 657 (C.C.A. 9th)—.

a case which illustrates the point of this discussion. Three educational endowment policies of $1000 each were issued on a father's life for the benefit of his child, the policies maturing at the end of 17, 18, and 19 years, respectively. Upon his previous death, they were not to be paid before maturity, but in that event the future proceeds would be doubled. The insured died before receiving the policies. The company refused to register the policies as effective, contending that they never came into force. Here was a total repudiation of a definite future obligation wholly unilateral, since the trial judge found that they were effec-

tive and that no premiums were due because the agent who was indebted to the applicant had promised to pay the first premiums. Upon those findings there ought to have been a decree in equity or a declaratory judgment establishing that the policies were effective, and that $6000 should be payable at maturity. But the Circuit Court of Appeals misapplied the doctrine of *Roehm* v. *Horst,* 178 U.S. 1, ignored the contrary state decisions (see citations in *Cobb* v. *Pacific Mutual Life Insurance Co.,* 51 Pac. (2d) 84), and allowed the child's guardian to recover at once as "damages" the present value of $6000 discounted at 7%, the legal rate, thus frustrating the purpose of the insured, injuring the child, and giving the company a benefit for which it had not contracted. The result cannot be supported. However, it has no application to the case at bar. The money was absolutely due, though payable in the future. Here no money will be due, even in the future, unless the respondent during each month shall be alive and continuously permanently disabled.

Under the combination policies the idea that repudiation may result in enormous future damages is a serious menace. (In *Wyll* v. *Pacific Mutual Life Insurance Company,* 3 Fed. Supp. 483, $180,000 was the sum claimed.) It is worthy of consideration by this Court. Although there is no repudiation here, the First Circuit Court of Appeals has encouraged the belief that every repudiation of such a combination policy is an invitation to sue in the Federal court for a lifetime of payments.

Respectfully submitted,

LOUIS H. COOKE,
F. H. NASH,
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Attorneys for Petitioner.

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DEC 12 '35

IN THE

Supreme Court of the United States

OCTOBER TERM, 1935.

No. 602.

NEW YORK LIFE INSURANCE COMPANY,
Petitioner,

v.

DEMETRIOS P. VIGLAS, Respondent.

RESPONDENT'S BRIEF.

In Opposition to the Petition for a Writ of Certiorari to the Circuit Court of Appeals for the First Circuit.

HARRIS J. BOORAS,
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Attorneys for Respondent.

LAWYERS' BRIEF & PUBLISHING CO.
BOSTON, MASS.

IN THE

Supreme Court of the United States

OCTOBER TERM, 1935.

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NEW YORK LIFE INSURANCE COMPANY,
Petitioner,

v.

DEMETRIOS P. VIGLAS,
Respondent.

RESPONDENT'S BRIEF.

In opposition to the Petition for a Writ of Certiorari to the Circuit Court of Appeals for the First Circuit.

To the Honorable the Justices of the Supreme Court of the United States:

The undersigned, on behalf of the above-named respondent, respectfully submit the following brief in opposition to the Petition for Writ of Certiorari to the Circuit Court of Appeals for the First Circuit.

Opinions Below.

The opinion of the District Court is not reported. It was filed November 22, 1934, and is found on pages 9 and 10 of the record. The opinion of the Circuit Court of Appeals appears at pages 13 and 19 of the record and is reported in 78 F. (2d) 829.

Additional Facts of the Case.

The facts of the case are substantially set out on pages 3 and 4 of the Petition. The complete statement of all the essential allegations are found in the substitute declaration (R. 3-7).

Respondent respectfully invites the Court's attention to the following important allegations:

The respondent commenced his action on November 9, 1933. Prior thereto, to wit, August 11, September 11, and October 11, 1933, the insurance company refused and failed to pay him the twenty dollars per month benefits due him under the disability clauses of the policy. On August 7, 1933, the company also failed to waive the payment of the semi-annual premium that fell due, and on September 19, 1933, it declared the policy as lapsed on its records.

The declaration further alleges that respondent (plaintiff below) lost the total and irrecoverable use of one hand and one foot—this condition under the policy is recognized to constitute total disability for life (R.23); and further, that the insured is no longer an insurable risk.

Jurisdiction. (Petition P. 2.)

The petitioner's (defendant's) demurrer to the respondent's (plaintiff's) declaration challenged the jurisdiction of

the District Court on the ground that the amount in controversy did not exceed $3000 exclusive of interest and costs.

Although the *ad damnum* in the respondent's writ was $20,000.00, and although the amount sought in good faith in the declaration as damages was about $17,308.00, the District Court, nevertheless, sustained the demurrer and entered judgment for the petitioner.

This judgment has been properly reversed by the Circuit Court of Appeals and the petition for a writ of certiorari should be denied.

As was stated in the case of *Kimel v. Missouri State Life Insurance Co.*, 71 F. (2d) 921:

> "Amount demanded by the plaintiff in petition, when not fictitious or merely colorable but claimed in good faith, and not amount of ultimate recovery, is test for determining whether case involves requisite jurisdictional 'amount in controversy'."

Fair v. Kohler Die & Specialty Co., 228 U. S. 22.

Question Presented. (Petition P. 2.)

The question presented is decidedly different from the one considered by this Honorable Court in the case of *Mobley v. New York Life Insurance Company*, 79 L. Ed. 936. It is as follows:

Where a life insurance company has repudiated its obligation to pay to the insured, who is totally and permanently disabled and who is no longer an insurable risk, benefits due him under the contract, has in fact refused to pay three monthly benefits already due, has failed to waive the payment of premium and has declared the policy *unconditionally* as lapsed: Can the insured treat the contract as ended and maintain one action for the recovery of all damages for the entire value of the contract?

Argument Against the Reasons Advanced for the Granting of the Writ.

1. *As to the ground that "the Circuit Court of Appeals refused to follow the decision of this Court in the Mobley case".*

The pertinent facts stated in this Court's opinion relied on as showing a total breach in the Mobley case (79 L. Ed. 938) are not as petitioner sets them out on page 7 of the petition.

The facts in the Mobley case are set out at length by this Honorable Court in its opinion. They may be summarized as follows:

Mobley became disabled sometime in January, 1931, when the company commenced paying him benefits under two policies. Several times between June 13, 1931, to March 1, 1933, the company concluded that Mobley was not totally disabled, and on each occasion notified Mobley that it would discontinue payments and would not waive premium. But in every instance, on his insistence that he was disabled, the company made further investigation and then changed its ruling, paid past benefits, resumed monthly benefits and waived premiums. On March 1, 1933, the company wrote him that in its opinion he was not totally disabled and that it would not make payments, and that the premium due February 7, 1933, became payable. Mobley replied he would take legal steps. On March 9, company wrote that the matter was receiving further consideration. On same day Mobley demanded $28,980.00 as total breach of the contracts and threatened suit. On March 17, company wrote that it would adhere to its decision not to make further payments. On April 13, company wrote him that one policy lapsed for nonpayment of premiums, and urged Mobley to

apply for reinstatement to protect his interests. On June 5, it advised him that since he had not applied for reinstatement, the company applied the value of the policy to purchase continued insurance until June 20, 1937. On June 9, notice was given him that premium on the other policy would be due on July 9. On July 8, attorney for Mobley wrote to the company that Mobley did not approve of the company's action of June 5. In answer the company wrote that it would give the claim further consideration and a new medical examination was made on July 24. As a result, company concluded that Mobley was totally disabled and on August 9, tendered him $910.00 accrued benefits, and written waiver of premiums. On July 24, suit was begun on one policy, and a few days later on the other. Company pleaded the correspondence and made tender in court. Thereafter, on the 13th of each month, company made payments in court.

On these facts this Honorable Court ruled that there was no repudiation of the entire contract.

In the instant case, as was well said by the Circuit Court of Appeals "the facts alleged are essentially different from those in the Mobley case . . ." (R. 17).

Viglas became totally and permanently disabled on September 11, 1931, and the company paid benefits up to July 11, 1933. On September 1, company notified him it would not make the payment which was due August 11, and that it would not waive the payment of premium due on August 7. Then it failed to make the payment due August 11, September 11, and October 11, and on September 19, it declared the policy as lapsed. Viglas was no longer an insurable risk. On November 9, 1933, he commenced his action for damages.

Here we have no re-examination by the company, no reconsideration of his claim, no tender of the benefits due,

and no offer to waive premiums and reinstate the policy. The lapsation of the policy was *unconditional* and at a time when the insured was totally and permanently disabled and was also not an insurable risk. No honest efforts were made by the company as in the Mobley case. What more should the company do in order to show complete disregard or repudiation of the contract?

The Circuit Court of Appeals followed exactly the opinion of this Court in the Mobley case. (R. 16.)

2. *As to the question of "whether the doctrine of anticipatory breach is applicable to the class of cases to which this one belongs".*

The question presented is not one as in the class of cases referred to as bilateral executory contracts. *Roehm v. Horst,* 178 U. S. 1. Rather it may be stated to be one as to damages recoverable because of the present breach and complete repudiation of an entire contract. (R. 17.)

The case belongs to that class of cases governed by the rule of law which may be stated as follows:

Where time for performance by the defendant has arrived and there is a present breach and a complete repudiation of the entire contract, it warrants the assessment of damages equivalent to the value to the plaintiff of the broken contract.

Pierce v. Tenn. Coal, Iron, etc., Co., 173 U. S. 1.
Lovell v. St. Louis Mutual Ins. Co., 111 U. S. 264.
Dunbar v. Dunbar, 190 U. S. 340.
Central Trust Co. of Ill. v. Chicago Auditorium Ass'n, 240 U. S. 541.
Parker v. Russell, 133 Mass. 74.
Day v. Conn. General Life Ins. Co., 45 Conn. 480.
Indiana Life Endowment Co. v. Reed, 103 N. E. 77.

In the case of *Federal Life Insurance Co. v. Rascoe,* (C. C. A. 6) 12 F. (2d) 693, in which certiorari was denied, 273 U. S. 722, and in which full damages were recovered, the Court said:

> "This is a single contract. The fact that the defendant is required to perform in part at stated intervals does not change its unitary character into a multiplicity of contracts, each relating to but one installment. If there has been an actual breach, coupled with repudiation, of this one contract, then, to avoid a multiplicity of suits, public policy requires that plaintiff may maintain but one action for the entire damages occasioned by such breach."

Millbum v. Royal Union Mutual Life, 234 S. W. (Mo.) 378.

Robbins v. Travellers Insurance Co., 269 N. Y. S. 841.

Equitable Life Assurance Society v. Pool, 71 S. W. (2d) 455.

3. *As to "the matter is one of great practical importance".*

The petitioner argues that unless the opinion of the Circuit Court is reversed, it will mean a great hardship upon insurance companies. What about the great hardship on the insureds in cases like the present, where the companies refuse to make payments and lapse policies? Must the insured be left to pursue his just claim by a multiplicity of suits. Why does not insurer waive premium under protest, or lapse the policy, conditionally, that it may reinstate it in case it discovers its error, if it desires to safeguard itself against one lawsuit for an entire breach?

The matter was just as important in 1926, when the Rascoe case was decided, as it is today, yet in that case—

Federal Life Insurance Co. v. Rascoe, 12 F. (2d) 693 (C. C. A. 6)—this Court denied a petition for a writ of certiorari. See 273 U. S. 722.

4. *As to the decision being contra "to that of the Circuit Court of Appeals for the Tenth Circuit in Kimel v. Missouri State Life Insurance Co., 71 F. (2d) 921." (Petition P. 9.)*

The respondent denies that the decision conflicts with the Kimel case.

In the Kimel case, there was no repudiation. The facts there, show that there was a dispute between the company and the assured as to the interpretation of a clause in the contract. The company claimed it owed less than what assured demanded. Each in good faith insisted on his own interpretation of the contract. The Court said:

> "An offer to perform in accordance with the promissor's interpretation of the contract, although erroneous, if made in good faith, is not such a clear and unequivocal refusal to perform as amounts to a renunciation giving rise to an anticipatory breach."

The decision of the Circuit Court does not conflict with that of any other Circuit Court. It is pursuant to law as laid down by the decisions of this Honorable Court hereinbefore cited.

Wherefore, the respondent respectfully urges that the petition be denied.

Respectfully submitted,

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FEB 15

Supreme Court of the United States.

OCTOBER TERM, 1935.

No. 602.

NEW YORK LIFE INSURANCE COMPANY,
Petitioner,

v.

DEMETRIOS P. VIGLAS,
Respondent.

BRIEF FOR THE RESPONDENT.

HARRIS J. BOORAS,
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Supreme Court of the United States.

OCTOBER TERM, 1935.

No. 602.

NEW YORK LIFE INSURANCE COMPANY,
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v.

DEMETRIOS P. VIGLAS,
Respondent.

BRIEF FOR THE RESPONDENT.

Jurisdiction and Travel of the Case.

This action at law, commenced in the District Court for the District of Massachusetts, comes before this Court upon certiorari to the Circuit Court of Appeals for the First Circuit. The writ is dated November 9, 1933, and names $20,000. as the ad damnum. The petitioner demurred to the declaration on the ground that the District Court had no jurisdiction, because the amount in controversy did not exceed $3,000. exclusive of interest and costs. The District Court sustained the demurrer; its opinion (R. 9, 10) is not reported. The Circuit Court reversed the judgment of the District Court; its opinion (R. 11, 17) is reported in 78 F. (2d) 829. This Court granted petition for certiorari on December 23, 1935 (R. 29).

Although the ad damnum in the respondent's writ was $20,000., and although the amount sought in good faith in the declaration as damages was about $17,308., the District Court nevertheless sustained the demurrer and entered judgment for the petitioner. This judgment was properly reversed by the Circuit Court of Appeals. The question of jurisdiction could not be adjudicated by the demurrer, for the amount claimed in good faith established jurisdiction, and not the possible amount of ultimate recovery. As was well stated in the case of *Kimel* v. *Missouri State Life Ins. Co.*, 71 F. (2d) 921:

> "Amount demanded by the plaintiff in petition, when not fictitious or merely colorable but claimed in good faith, and not amount of ultimate recovery, is test for determining whether case involves requisite jurisdictional 'amount in controversy'."
>
> *Fair* v. *Kohler Die & Specialty Co.*, 228 U.S. 22.

The demurrer should have been overruled on this ground, therefore, if not on the substantive questions of law hereinafter considered.

Additional Facts of the Case, and Question Presented.

The facts of the case, as admitted by the demurrer, are fully set out in the respondent's substitute declaration (R. 3, 7). Respondent respectfully invites the Court's attention to the following important allegations:

This action was commenced November 9, 1933. Prior thereto, to wit, August 11, September 11, and October 11, 1933, the insurance company refused and failed to pay respondent the $20. per month benefits due him under the disability clauses of the policy (R. 20). On August 7, 1933, the company also failed to waive the payment of the semi-annual premium that fell due, and on September 19, 1933, it declared the policy *unconditionally* lapsed on its records. The declaration further alleges that the respondent (plaintiff be-

low) lost the total and irrecoverable use of one hand and one foot—this condition under the policy is recognized to constitute total disability for life; and further, that he was no longer an insurable risk.

The question presented, therefore, is decidedly different from the one considered by this Honorable Court in the case of *Mobley* v. *New York Life Insurance Co.*, 295 U.S. 632. It is as follows: Where a life insurance company has repudiated its obligation to pay to the insured, who is totally and permanently disabled, and who is no longer an insurable risk, benefits due him under the contract, has in fact refused to pay three monthly benefits already due, has failed to waive the payment of premium, and has declared the policy unconditionally lapsed: can the insured treat the contract as ended, and maintain one action for the recovery of all damages for the entire value of the broken contract?

Points and Authorities.

The respondent will direct his argument to the points and authorities considered in the petitioner's brief.

1. *As to the point that: "The case is governed by the decision of this Court in the recent case of Mobley v. New York Life Insurance Company, 295 U.S. 632."*

The pertinent facts stated in this Court's opinion, relied on as showing a total breach in the *Mobley Case*, are not as petitioner sets them out in its brief. They may be summarized as follows:

Mobley became disabled sometime in January, 1931, when the company commenced paying him benefits under two policies. Several times between June 13, 1931, to March 1, 1933, the company concluded that Mobley was not totally disabled, and on each occasion notified Mobley that it would discontinue payments and would not waive premium. But in every instance, on his insistence that he was disabled, the company made further investigation and then changed its ruling, paid past benefits, resumed monthly benefits and waived premiums. On March 1, 1933, the company wrote him that in its opinion he was not totally disabled and that

it would not make payments, and that the premium due February 7, 1933, became payable. Mobley replied he would take legal steps. On March 9, company wrote that the matter was receiving further consideration. On same day Mobley demanded $28,980. as total breach of the contracts and threatened suit. On March 17, company wrote that it would adhere to its decision not to make further payments. On April 13, company wrote him that one policy lapsed for non-payment of premiums, and urged Mobley to apply for reinstatement to protect his interests. On June 5, it advised him that since he had not applied for reinstatement, the company applied the value of the policy to purchase continued insurance until June 20, 1937. On June 9, notice was given him that premium on the other policy would be due on July 9. On July 8, attorney for Mobley wrote to the company that Mobley did not approve of the company's action of June 5. In answer the company wrote that it would give the claim further consideration and a new medical examination was made on July 24. As a result, the company concluded that Mobley was totally disabled and on August 9, tendered him $910. accrued benefits, and written waiver of premiums. On July 24, suit was begun on one policy, and a few days later on the other. The company pleaded the correspondence and made tender in court. Thereafter, on the 13th of each month, the company made payments in court.

On these facts this Honorable Court ruled that there was no repudiation of the entire contract.

In the instant case, as was well said by the Circuit Court of Appeals "the facts alleged are essentially different from those in the Mobley case . . . . . " (R. 15).

Viglas became totally and permanently disabled on September 11, 1931, and the company paid benefits up to July 11, 1933. On September 1, the company notified him it would not make payment which was due August 11, and that it would not waive the payment of premium due on August 7. Then it failed to make the payment due August 11, September 11, and October 11, and on September 19, it declared the policy as lapsed. Viglas was no longer an insurable risk. On November 9, 1933, he commenced his action for damages.

In the *Mobley* case, the correspondence between the company and the assured, the continuous examination of the assured by the company's doctors, even after lapsation, the invitation on the part of the company to reinstate the policies, the offer on the part of the company to pay accrued benefits, and to waive the payment of premiums, conclusively establish the fact that the company did not intend to terminate the policy unconditionally and without qualification, but reflect an honest endeavor on the company's part to place the assured in status quo, reinstate the policy, and pay him all accrued benefits.

In the instant case, these facts do not appear at all. After the company failed to make three payments that had fallen due, and after it failed to waive the payment of premium, it unconditionally declared the policy as lapsed, all of which happened at a time when the assured was totally and permanently disabled, and when he was no longer an insurable risk, and before suit was brought. The Court please note that the declaration alleges that the assured had lost the irrecoverable use of one hand and one foot, a condition which is recognized under the terms of the policy to constitute total disability for life (R. 20). That being so, the liability was fixed during the entire life of the assured. What more should the company do in order to show complete disregard and repudiation of the contract?

The petitioner argues that its acts did not amount to repudiation or a total breach of the contract. If that be so, what did such acts amount to? Does lapsation mean an end of the policy, giving the right to the assured to consider it as ended? If the petitioner, therefore, considered the policy at an end by its lapsation of it, how can it now take an inconsistent view and argue that the respondent may recover only the benefits that had accrued or will accrue under the contract, when the contract is at an end? Can it be argued, as the petitioner stresses in its brief, that the lapsation and ending of the contract has no effect on the series of so-called contracts flowing from the policy, and that the same are still alive and suits can only be brought upon them? Either the policy is dead, or it is alive. It has either died by the lapsation and as

a consequence suit may be brought for its breach, or it is still alive in spite of the lapsation and ending of it by the company, and suits for the collection of each monthly benefit must be brought under it. If the question were put to the petitioner as to what it meant by the lapsing of the policy, certainly the only answer it could give was that the policy was at an end, and that the company was no longer liable upon it. Certainly they did not intend that it would not lapse; that being so, respondent is entitled to treat the policy as at an end, and sue for full damages arising from such breach.

In *Robins* v. *Travelers Insurance Co.* (February, 1934) 269 N.Y.S. 841, it was held that where disability insurer repudiated its contractual obligation to pay disability benefits, some of which had already accrued, insured was entitled to treat the contract as ended, and maintain a single action immediately to recover all damages occasioned by such breach, the Court observing, "in the present case there is more than repudiation before maturity because defendant has definitely breached the contract by refusing to pay disability benefits already due . . . . . Here benefits are due and repudiation would force plaintiff to resort to repeated law suits."

Equitable Life Assurance Society v. *Pool*, 71 S.W. (2d) 455, (Ark., 1934).

Millbum v. *Royal Union Mutual Life*, 234 S.W. (Mo.) 378.

Minn. Mutual Life v. *Marshall*, 79 Fed. (N.D.) 977.

Indiana Life Endowment Co. v. *Reed*, 103 N.E. (Ind.) 77.

These decisions, and those hereinafter cited in answer to the second point raised in the petitioner's brief, all rest on sound judgment and equity, in that, if in accordance with the uniformity of decisions, contracts of insurance ought to be construed in a light most favorable to the insured, why should the burden be placed upon the insured and not upon the insurer? For in these cases, the insurer, by some alleged claim that in its judgment the insured is not totally disabled, loses nothing by refusing to make payments and waive premium.

The insured, who may be totally and permanently disabled, in order to safeguard the policy from ending by lapsation, must on one hand pay premiums under protest, and on the other, must bring law suits every month and prove his disability in every case in order to collect every monthly installment through a court trial. Meantime, his mind is disturbed, he cannot pledge the policy to borrow any money if he needs it, he stands a chance of losing important witnesses if he has to sue every month during the life of the policy, and he is thereby completely at the mercy of the insurance company. The company has nothing to lose, but the insured has everything at stake, although he has neither breached his contract nor has he in any way disavowed it. If, in his honest opinion, the insured should feel that he is totally disabled and thereby does not pay the premium under protest to prevent the policy from lapsation, and it should later be proven at a trial that he was not in fact totally disabled within the meaning of the policy provisions, it would be absolutely impossible for him to reinstate his policy if he be not a proper insurable risk. His policy is thereby at an end. However, it is strenuously argued by the petitioner that if the insurance company lapses the policy and its judgment is found to be mistaken, its act of lapsation is nugatory and the insurance company should suffer no hardship of any nature.

Take for example, the present case. If at the trial on the merits, the respondent, who honestly believes in his total disability, should fail to prove that as a fact, in accordance with the provisions of the policy, he is absolutely deprived of the policy by the lapsation, and it is at an end and he has no remedy whatever under the policy, except perhaps to petition for reinstatement provided he is an insurable risk. In this case it is alleged and admitted by the demurrer that the respondent is not an insurable risk, and consequently his policy must be declared at an end. The petitioner argues that this result should not obtain as against it, in spite of the fact that it proceeded to lapse the policy unconditionally. Law and justice requires that if both parties are to be treated equally, and if their acts and omissions are to be given the same weight, they should suffer the same consequences. If the in-

surance company does not desire the insured to recover in one action all damages flowing from the repudiation of the policy, its only course is either to waive the payment of premium under protest and thereby not lapse the policy, or lapse the policy on condition that the same be reinstated if the company's judgment is in error.

2. *As to the point that: "The doctrine of anticipatory breach which alone could sustain the respondent's position, does not apply to the case."*

Respondent agrees with learned counsel for petitioner that the doctrine of anticipatory breach does not apply to this case. The opinion of the Circuit Court of Appeals, in a most clear and logical manner, discusses the principles which govern the case at bar (R. 11, 17). The case belongs to that class of cases governed by the rule of law which may be stated as follows: Where time for performance by the defendant has arrived, and there is a present breach and a complete repudiation of the entire contract, it warrants the assessment of damages equivalent to the value to the plaintiff of the broken contract.

Pierce v. *Tenn. Coal, Iron, etc. Co.*, 173 U.S. 1.
Lovell v. *St. Louis Mutual Ins. Co.*, 111 U.S. 264.
Dunbar v. *Dunbar*, 190 U.S. 340.
Parker v. *Russell*, 133 Mass. 74.
Central Trust Co. of Ill. v. *Chicago Auditorium Ass'n.*, 240 U.S. 541.
Day v. *Conn. General Life Ins. Co.*, 45 Conn. 480.
Indiana Life Endowment Co. v. *Reed*, 103 N.E. 77.
O'Neil v. *Supreme Council American Legion of Honor*, 57 Atlantic (N.J.) 463.

In the case of *Federal Life Insurance Co.* v. *Rascoe*, (C.C.A. 6), 12 F. (2d) 693, in which, certiorari was denied, 273 U.S. 722, and in which full damages were recovered, the Court said:

"This is a single contract. The fact that the defendant is required to perform in part at stated intervals does not

> change its unitary character into a multiplicity of contracts, each relating to but one installment. If there has been an actual breach, coupled with repudiation, of this one contract, then, to avoid a multiplicity of suits, public policy requires that plaintiff may maintain but one action for the entire damages occasioned by such breach."

In *Pierce* v. *Tenn. Coal, Iron, etc. Co.*, supra, repudiation by the defendant of an agreement by it to pay the plaintiff, who had been injured, stated monthly payments as long as his disability should continue, coupled with nonpayment of sums due, was held to warrant the assessment of damages equivalent to the value to the plaintiff of the broken contract. Quoting from the language of Justice Gray:

> "The defendant committed an absolute breach of the contract at a time when the plaintiff was entitled to require performance. The plaintiff was not bound to wait to see if the defendant would change its decision and take him back into its service; or to resort to successive actions for damages from time to time; or to leave the whole of his damages to be recovered by his personal representative after his death, but he has the right to elect to treat the contract as absolutely and finally broken by the defendant; to maintain this action, once for all, as for a total breach of the entire contract; and to recover all that he would have received in the future as well as in the past if the contract had been kept. In so doing he would simply recover the value of the contract to him at the time of the breach, including all the damages, past or future, resulting from the total breach of the contract."

In the instant case, liability became fixed to pay respondent monthly benefits for the rest of his life, for he alleges, in addition to his other disabilities, that he lost the total and irrecoverable use of one hand and one foot. This allegation is admitted by the demurrer. The policy provides (R. 20), "The total and irrecoverable loss of sight of both eyes or of the use of both hands or of both feet, or of one hand and one foot, shall constitute total disability for life." The petitioner failed to make three monthly payments and also to waive the premium at a time when the respondent was entitled to re-

quire performance. Then it unconditionally lapsed the policy. The respondent was not bound to wait to see if the petitioner would change its decision and pay the installments that had fallen due, and reinstate the policy; or to resort to successive actions for damages from time to time. However, he had the right to elect to treat the contract as absolutely and finally broken by the petitioner; to maintain his action once and for all, as for a total breach of the entire contract; and to recover all that he would have received in the future as well as in the past, if the contract had been kept.

Eastern Tenn. etc. R.R. v. *Taub*, 7 Lea. 397.

Cutter v. *Gillette*, 163 Mass. 95.

Anson on Contracts, Am. Ed. Ch. XV, pp. 442, 445.

Restatement Law of Contracts, Am. Law Institute, Rep. Samuel Williston. Tentative Draft No. 7, explanatory notes on contracts March 1, 1930, 14 Harvard Law Review 432.

In *Dunbar* v. *Dunbar*, cited supra, the contract was to pay a divorced wife, "during her life or until she marries for her maintenance and support, yearly the sum of $500.". It was held that a discharge in bankruptcy did not discharge the husband from installments falling due after the bankruptcy; on the grounds that the wife's claim for such payments was not provable in bankruptcy because of the impossibility of calculating the continuance of widowhood so as to base a valuation upon it. Bankruptcy was considered a breach of the contract. If the duration of widowhood could be figured like the expectancy of life from death mortality tables, the inference to be drawn from the decision is that the Court would have said that the claim was provable in bankruptcy for a liquidated amount. This case is analogous to the case at bar, with the exception that in the instant case the expectancy of life of the respondent is ascertainable, whereas in the *Dunbar* case the duration of widowhood was not.

The petitioner in its brief argues that "lapse signifies termination of the policy in accordance with its provisions,

not repudiation which would terminate the contract contrary to its provisions." It is agreed that lapse signifies termination of the policy in accordance with its provisions, but such termination was brought about by the wrongful failure on the part of the petitioner to waive the payment of premium in accordance with the provisions of the policy, and at a time and under circumstances when the respondent was entitled to require performance. If the termination of the policy through lapsation, therefore, was brought about by this wrongful act of the petitioner, certainly the petitioner would not argue that such termination of the contract is not putting it to an end. What then does termination mean? Under these circumstances it means repudiation of the contract.

In *Parker* v. *Russell*, cited supra, failure by the defendant to make any payments for about two years on a contract to support the plaintiff during the latter's life, was held to warrant a finding that the entire contract was broken and assessment of damages equivalent to the value of the contract to the plaintiff.

It is respectfully submitted that the principle of the foregoing decisions is applicable to the case at bar.

3. *As to the point: "Aside from the rules of law heretofore discussed, it would be unjust to permit the recovery sought by the respondent."*

The petitioner argues at length that unless the opinion of the Circuit Court is reversed, it will mean a great hardship on insurance companies. What about the great hardship on the insureds in cases like the present, where the companies refuse to make payments and lapse policies? Must the insured be left to pursue his just claim by a multiplicity of suits? It is argued, in behalf of the petitioner, that it never agreed in the policy to pay a lump sum, and further that what it agreed to do and what the assured bargained for, was that it should make payments monthly. That is quite correct, so long as the bargain is kept up, and no wrongful withholding of payments when they fall due is made, and no lapsation of the policy is decreed by the company. There is no sound reason, however, when the insurer has wrongfully violated the

provisions of the policy and has lapsed the same, why the insured should be left to the only remedy of suing monthly for that which is due him. By being placed in a position where his mind is disturbed through litigation, he stands the chance of losing important witnesses; and while he is in the destitute condition of being totally and permanently disabled, he is thus indirectly placed at the mercy of the insurance company.

In answer to the lengthy argument advanced by the learned counsel of the petitioner on this point, the Court please consider also that usually the insured who is totally and permanently disabled comes from the walks of life of the worker, the humble, and the poor, and faithfully expects the monthly payment under his policy for his maintenance and support, and for the maintenance and support of his loved ones. He can perform no work, for he suffers from illness, and is of total inability to do anything. While in that state of mind and suffering, the insurance company decides to stop the payments, and calls upon him for premium. Usually he is not in a position to even pay premium under protest, and the policy lapses. If he desires to enforce payments, he must bring suit to collect the monthly benefit; he must engage counsel, he must produce witnesses and medical men in court, and if the company should refuse every month to make the payment due, he must repeat this in every instance. The company has nothing to lose, but insured has everything destroyed. Why should he be deprived of his right to collect in one sum the damages that he is entitled to, if the company wrongfully lapses the policy? It is argued, in behalf of the petitioner, that there is no practical convenience in allowing such a recovery, and that justice does not require that a plaintiff have this novel remedy. In answer, we respectfully submit that justice not only requires but necessitates that such a remedy be extended for the relief of the insured, and that such remedy is not novel, but is founded on fundamental principles of law and equity.

It is further argued, on behalf of the petitioner, that damages are speculative and conjectural. If damages flowing from the breach of this contract can be termed as resulting

from "a prophecy", then all damages in every case of tort or contract can be given the same stigma of uncertainty. The objections to damages argued in the petitioner's brief may be said to apply to all forms of damages, yet the recovery of such damages is necessary and desirable in order to end litigation, and once and for all give to the one who has been wronged what he has suffered or would suffer. Practical necessity requires that the Court apply the rule laid down in *Pierce* v. *Tenn. Coal, Iron etc., Co.* and *Parker* v. *Russell,* cited supra, to the case at bar. If, as the petitioner argues, the matter would result in great practical hardship for it, the only answer to that is that they should not lapse policies unconditionally, and thus throw all the burden, inconvenience, and worry upon the destitute insured at a time when he is totally and permanently disabled, and when he is no longer an insurable risk. The matter was just as important in 1926, when the case of *Federal Life Insurance Co.* v. *Rascoe,* supra, was decided, as it is today, yet in that case this Honorable Court denied a petition for writ of certiorari.

Respectfully submitted,

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SUPREME COURT OF THE UNITED STATES.

No. 602.—October Term, 1935.

New York Life Insurance Company, Petitioner, *vs.* Demetrios P. Viglas, Respondent. } On Writ of Certiorari to the United States Circuit Court of Appeals for the First Circuit.

[March 30, 1936.]

Mr. Justice Cardozo delivered the opinion of the Court.

The case, which is here upon demurrer to a declaration, depends for its solution upon the nature of the breach of contract imputed to the defendant, the petitioner in this court, and upon the measure of the damages recoverable therefor.

From the declaration we learn the following: Respondent received from petitioner on February 7, 1927, a policy of insurance for $2,000 payable at his death. The consideration was a semi-annual premium of $38 payable during his life, but for not more than twenty years. If, however, the insured became totally and permanently disabled before the age of sixty, the company, petitioner, was to pay him a monthly income at an agreed rate and was to waive the payment of any premium that would otherwise be due. Disability was to be considered total when the insured was so affected by bodily injury or disease as to be wholly prevented from performing any work, from following any occupation, or from engaging in any business for remuneration or profit. In particular, "the total and irrecoverable loss of the sight of both eyes or of the use of both hands or of both feet or of one hand and one foot" was to constitute "total disability for life." Before making any income payment or waiving any premium the company might demand due proof of the continuance of total disability, not oftener, however, than once a year after such disability had continued for two full years. Upon failure to furnish such proof, or if the insured performed any work, or followed any occupation, or engaged in any business for remuneration or profit, "no further income payments" were to be made, "nor premiums waived." If at the time of a default in the payment of a premium, the insured was disabled

within the definition of the policy, the insurance was to be reinstated, provided, however, that within six months after the default proofs of such disability were received by the insurer. In any event, reinstatement would be permitted at any time within five years upon evidence of insurability satisfactory to the insurer and upon payment of overdue premiums with interest at five per cent. Finally, the insured, though in default, was to have the benefit of surrender values in the form either of cash or of temporary insurance or of participating paid-up insurance according to his choice.

On September 11, 1931, the insured, according to the declaration, lost "the total and irrecoverable use" of one hand and one foot, and became totally and permanently disabled. Upon proof of his condition the company paid him the monthly benefits called for by the policy from October 11, 1931, to July 11, 1933, and during the same period waived the payment of semi-annual premiums. It refused to make a monthly payment in August, 1933, and refused the same month to waive a semi-annual premium, "asserting to the plaintiff as its ground for such refusal that since it appeared to the defendant that for some time past the plaintiff had not been continuously totally disabled within the meaning of the disability benefit provision of the policy, the defendant would make no further monthly disability payments, and that the premiums due on and after August 7, 1933, would be payable in conformity with the terms of the contract." Later, upon the expiration of a term of grace, "the defendant, on or about September 19, 1933, declared the policy as lapsed upon its records." Plaintiff has elected to treat the defendant's acts "as a repudiation and denunciation of the entire contract", relieving him on his part from any further obligation.

There are two counts to his declaration. In the first, after stating the foregoing facts, he claims the cash surrender value that the policy will have in February, 1969, if he lives until that time, the date being chosen with reference to his expectancy of life under the American Table of Mortality. This value, $1,408, is less than the amount necessary to give jurisdiction in accordance with the Judicial Code. Judicial Code, § 24; 28 U. S. C., § 41. In the second count, after stating the same facts, he claims for damages the total benefits that will be payable to him during the same period of expectancy, if he lives that long and his disability con-

tinues. The damages so computed are $15,900. No deduction is made on account of future premiums, for by hypothesis the disability will continue during life. The defendant demurred to both counts, stating in the demurrer that the declaration sets forth a cause of action for the benefits and premiums accruing prior to the date of the writ, and for nothing in excess thereof. In that view the recovery will be only $98, which is less than the jurisdictional amount. The District Court sustained the demurrer, and gave judgment for the defendant. The Court of Appeals for the First Circuit reversed. 78 F. (2d) 829. A writ of certiorari issued to resolve a claim of conflict with a decision of this court.

Upon the showing made in the complaint there was neither a repudiation of the policy nor such a breach of its provisions as to make conditional and future benefits the measure of recovery.

Repudiation there was none as the term is known to the law. Petitioner did not disclaim the intention or the duty to shape its conduct in accordance with the provisions of the contract. Far from repudiating those provisions, it appealed to their authority and endeavored to apply them. If the insured was still disabled, monthly benefits were payable, and there should have been a waiver of the premium. If he had recovered the use of hand or foot and was not otherwise disabled, his right to benefits had ceased, and the payment of the premium was again a contractual condition. There is nothing to show that the insurer was not acting in good faith in giving notice of its contention that the disability was over. *Mobley* v. *New York Life Insurance Co.*, 295 U. S. 632, 638. If it made a mistake, there was a breach of a provision of the policy with liability for any damages appropriate thereto. We do not pause at the moment to fix the proper measure. Enough in this connection that at that stage of the transaction there had been no renunciation or abandonment of the contract as a whole. *Mobley* v. *New York Life Insurance Co., supra; Dingley* v. *Oler*, 117 U. S. 490, 503; *Roehm* v. *Horst*, 178 U. S. 1, 14, 15; *Pierce* v. *Tennessee Coal, Iron and R. Co.*, 173 U. S. 1, 3, 11.

Renunciation or abandonment, if not effected at that stage, became consummate in the plaintiff's view at the end of the period of grace when the company declared the policy "lapsed upon its records". Throughout the plaintiff's argument the declaration of a lapse is treated as equivalent to a declaration that the con-

tract is a nullity. But the two are widely different under such a policy as this.[1] The policy survived for many purposes as an enforcible obligation, though default in the payment of premiums had brought about a change of rights and liabilities. The insurer was still subject to a duty to give the insured the benefit of the stipulated surrender privileges, cash or new insurance. It was still subject to a duty upon proof within six months that the disability continued to reinstate the policy as if no default had occurred. None of these duties was renounced. None of them was questioned. Indeed, there is lacking an allegation that notice of the entry on the records was given to the plaintiff, or that what was recorded amounted to more than a private memorandum. In that respect the case is weaker for the plaintiff than *Mobley* v. *New York Life Insurance Co., supra,* decided at the last term. There also the controversy turned upon the rejection of a claim of disability under a like contract of insurance. The insurer took the ground that the disability had ended and that premiums would not be waived. Upon default it gave notice to the insured that the policy had lapsed. We held that the breach fell short of an unconditional abandonment. On the other hand, following the notice and before the service of a summons there were acts and declarations pointing to an understanding between insurer and insured that the lapse was not definitive, but was open to recall. These differences are such as to take from that decision the quality of a controlling precedent, though the analogy it offers is cogent and persuasive. Viewing the case before us independently, we hold that upon the facts declared in the complaint the insurer did not repudiate the obligation of the contract, but did commit a breach for which it is answerable in damages.

What the damages would be if there had been complete repudiation we do not now decide. Cf. *Kelly* v. *Security Mutual Life Insurance Co.,* 186 N. Y. 16; *O'Neill* v. *Supreme Council A. L. of H.,* 70 N. J. L. 410, 415. For breach short of repudiation or an intentional abandonment equivalent thereto, the damages under such a policy as this do not exceed the benefits in default at the commencement of the suit. Full justice will thus be done alike to insured and to insurer. The insured, if he proves that the benefits are due, will have a judgment effective to reinstate his policy. The insurer

[1] See the cases collected in Vance on Insurance, 2nd ed., pp. 283, 301, 302.

will be saved from a heavy, perhaps a crushing liability as the consequence of a claim of right not charged to have been made as a disingenuous pretense. Cf. *Armstrong* v. *Ross*, 61 W. Va. 38, 48. So the courts have held with an impressive concord of opinion.[2] *Federal Life Insurance Co.* v. *Rascoe*, 12 F. (2d) 693, one of the few decisions to the contrary, was disapproved in *Mobley's* case (p. 639), and is now disapproved again.

We have no thought to suggest an invariable rule whereby the full value of a bargain may never be recovered for any breach of contract falling short of repudiation or intentional abandonment. All depends upon the circumstances. *Helgar Corporation* v. *Warner's Features, Inc.*, 222 N. Y. 449, 452, 453, 454.[3] There may be times when justice requires that irrespective of repudiation or abandonment the sufferer from the breach shall be relieved of a duty to treat the contract as subsisting or to hold himself in readiness to perform it in the future. *Roehm* v. *Horst, supra*, pp. 17, 18; *Nichols* v. *Scranton Steel Co.*, 137 N. Y. 471, 487. Generally this is so where the contract is a bilateral one with continuing obligations, as where a manufacturer has undertaken to deliver merchandise in instalments. *Norrington* v. *Wright*, 115 U. S. 188; *Wolfert* v. *Caledonia Springs Ice Co.*, 195 N. Y. 118. Even then, the rights that are his may depend upon the grounds of the rejection or the nature of the default, whether unintentional or wilful. *Helgar Corporation* v. *Warner's Features, Inc., supra.* On the other hand, a party to a contract who has no longer any obliga-

[2] Daley *v.* People's Building, Loan & Saving Association, 178 Mass. 13, 18; Howard *v.* Benefit Association of Railway Employees, 239 Ky. 465, 468; Woods *v.* Provident Life and Accident Insurance Co., 240 Ky. 398; Indiana Life Endowment Co. *v.* Reed, 54 Ind. App. 450, 460, 461; Mutual Life Insurance Co. *v.* Marsh, 186 Ark. 861, 869; Massachusetts Protective Association, Inc. *v.* Jurney, 188 Ark. 821, 826; Cobb *v.* Pacific Mutual Life Insurance Co., 90 Cal. Dec. 401, 405, 407; Brix *v.* People's Mutual Life Insurance Co., 89 Cal. Dec. 221; Atkinson *v.* Railroad Employes Mutual Relief Society, 160 Tenn. 158, 167, 168; Atlantic Life Insurance Co. *v.* Serio, 171 Miss. 726, 730; Allen *v.* National Life & Accident Insurance Co., 228 Mo. App. 450, 452; Puckett *v.* National Annuity Association, 134 Mo. App. 501; Garbush *v.* Order of United Commercial Travelers, 178 Minn. 535, 539; Kimel *v.* Missouri State Life Insurance Co., 71 F. (2d) 921, 923; Menssen *v.* Travelers' Insurance Co., 5 F. Supp. 114; Ginsburg *v.* Pacific Mutual Life Insurance Co., 5 F. Supp. 296; Hines *v.* Fidelity Mutual Life Insurance Co., 6 F. Supp. 692; Kithcart *v.* Metropolitan Life Insurance Co., 1 F. Supp. 719; Wyll *v.* Pacific Mutual Life Insurance Co., 3 F. Supp. 483; Parks *v.* Maryland Casualty Co., 59 F. (2d) 737; cf. Kelly *v.* Security Mutual Life Insurance Co., 186 N. Y. 16; Killian *v.* Metropolitan Life Insurance Co., 251 N. Y. 44, 48.

[3] For a collection of the cases, see Williston, Contracts, vol. 2, §§ 864, 866, 867, 870; vol. 3, § 1290; and cf. Restatement, Law of Contracts, vol. 1, § 275.

tion of performance on his side but is in the position of an annuitant or a creditor exacting payment from a debtor, may be compelled to wait for the instalments as they severally mature, just as a landlord may not accelerate the rent for the residue of the term because the rent is in default for a month or for a year. *McCready* v. *Lindenborn*, 172 N. Y. 400, 408; cf. *National Machine & Tool Co.* v. *Standard Shoe Machinery Co.*, 181 Mass. 275, 279; *Wharton & Co.* v. *Winch*, 140 N. Y. 287. With the aid of this analysis one discovers the rationale of the cases which have stated at times, though with needless generality, that by reason of the subject matter of the undertaking the rule applicable to contracts for the payment of money is not the same as that applicable for the performance of services or the delivery of merchandise. Cf. *Roehm* v. *Horst, supra*, at p. 17; *Moore* v. *Security Trust & Life Insurance Co.*, 168 Fed. 496, 503; *Howard* v. *Benefit Association of Railroad Employees*, 239 Ky. 465, 470; *Washington County* v. *Williams*, 111 Fed. 801, 810; Restatement, Law of Contracts, § 316. The root of any valid distinction is not in the difference between money and merchandise or between money and services. What counts decisively is the relation between the maintenance of the contract and the frustration of the ends it was expected to subserve. The ascertainment of this relation calls for something more than the mechanical application of a uniform formula. To determine whether a breach avoids the contract as a whole one must consider what is necessary to work out reparation in varying conditions.

If that test be applied, the declaration will not stand. The plaintiff does not need redress in respect of unmatured instalments in order to put himself in a position to shape his conduct for the future. If he is already in default for the non-payment of a premium, he will not be in any worse predicament by multiplying the defaults thereafter. On the other hand, if his default is unreal because the premiums had been waived, the insurer will be estopped from insisting upon later premiums until the declaration of a lapse has been canceled or withdrawn. Besides, if the disability is permanent, there will be nothing more to pay. The law will be able to offer appropriate relief "where compensation is wilfully and contumaciously withheld." *Cobb* v. *Pacific Mutual Life Insurance Co.*, 90 Cal. Dec. 401, 407.

We have refrained in what has been written from developing the distinction between an anticipatory breach and others. The line of

division between the two has not always been preserved with consistency or clearness. To blur it is prejudicial to accuracy of thought as well as precision of terminology. Strictly an anticipatory breach is one committed before the time has come when there is a present duty of performance. *Roehm* v. *Horst, supra;* Pollock on Contracts, 9th ed., p. 293; Williston, Contracts, vol. 3, § 1296 *et seq.*, collecting the decisions. It is the outcome of words or acts evincing an intention to refuse performance in the future. On the other hand, there are times, as we have seen, when the breach of a present duty, though only partial in its extension, may confer upon the injured party the privilege at his election to deal with the contract as if broken altogether. A loose practice has been growing up whereby the breach on such occasions is spoken of as anticipatory, whereas in truth it is strictly present, though with consequences effective upon performance in the future. The declaration in the case at hand makes a showing of a present breach. It does not make a showing of a breach so wilful and material as to make acceleration of future benefits essential to the attainment of present reparation. *Helgar Corporation* v. *Warner's Features, Inc., supra.*

The judgment of the Court of Appeals should be reversed and that of the District Court affirmed.

It is so ordered.

A true copy.

Test:

Clerk, Supreme Court, U. S.